COUNTY OF LOS ANGELES

HIV/AIDS COMPREHENSIVE CARE PLAN

August 2002

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Prepared for
The Office of AIDS Programs and Policy and
The Los Angeles County Commission on HIV Health Services

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Submitted by
Partnership for Community Health, Inc.

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Abbreviations

ADAP	AIDS Drug Assistance Program
Af Am	African American
API	Asian / Pacific Islander
ASD	Adult/Adolescent Spectrum of Disease
ASO	AIDS Service Organization
CHHS	Commission on HIV Health Services
EMA	Eligible Metropolitan Area
HARS	HIV/AIDS Reporting System
HAV	hepatitis A
HCV	hepatitis C
HET	Heterosexual
IDU	Injecting drug user
IMACS	Information Management of AIDS Clients and Services
Los Angeles County	Los Angeles County
MSM	Men-who-have-sex-with-men
MSMC	Men-who-have-sex-with-men of color
Native Am	Native American
OAPP	Office of AIDS Programs and Policy
OI	Opportunistic infection
PCH	Partnership for Community Health
PLWH/A	Person living w/ HIV/AIDS
PP&E / P&P	Planning, Priorities, and Evaluation renamed to Priorities and Planning Committee
RWCA	Ryan White CARE Act
SHAS	Supplemental HIV/AIDS Study
SPA	Service Planning Area
STD	Sexually transmitted diseases
TB	Tuberculosis
TG	Transgender
VA	Veteran's Assistance
WCBA	Women of Childbearing Age
Youth	PLWH/A 24 years of age or younger

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EXECUTIVE SUMMARY

Positive Outcomes With Some Cautions

Los Angeles County receives high marks for its HIV/AIDS care system. The outcomes suggest significant declines in mortality and morbidity, and quality of life has remained the same or improved for PLWH/A.

At the same time, Los Angeles County faces significant challenges in meeting the needs and unmet needs of PLWH/A, and overcoming barriers in accessing and maintaining treatment in the following context.

First, mortality and morbidly rates have stabilized and are no longer declining.

Second, the number of people needing treatment has increased. While there are not reliable estimates of increased PLWH, the number of PLWA has increased from 13,653 in 1994 to 16,547 in 2001. At the same time, the cost of treatment and medication continues to rise. Consequently, if funding remains flat, the result will be a decrease in the per-capita contribution to care provided by the Ryan White CARE Act. At the end of 2001, close to 20,000 clients were in Los Angeles County's care system. Similarly, there were 23,000 more people who seek care outside the CARE Act-funded service system, or know their diagnosis, but have not accessed the care system.

Accordingly, a primary goal of the Los Angeles County's Comprehensive Care Plan is to make even more effective and efficient use of Ryan White CARE Act funds. As a first step in that process, it is essential to understand the composites of PLWH/A in Los Angeles County.

Changing Profile of the HIV/AIDS Epidemic

Los Angeles County is witness to many different HIV epidemics divided by age, race and lifestyle. There are 11 special populations identified and profiled in the Comprehensive Care Plan. A summary of those groups suggest:

Anglos and MSM are more likely to be represented in the "mature epidemic" – longer term survivors and a large proportion of whom are diagnosed with AIDS. Although there is great diversity in the group, on average:

- The age of the Anglo MSM living with AIDS is in his late 30's or 40's.
- Since a majority of them are diagnosed with AIDS, a large number of them are disabled and able to access MediCal.
- Many have had work histories, making them eligible for Medicare.
- Most are in care, and those out-of-care usually have made an informed decision to not be in care
- The population has a history of activism, and the earlier ASOs served them when they were first infected, and continue to serve them today.

- Many of them have "spent down" their financial resources to meet the MediCal criteria, and most are fairly savvy about the kinds and options of services available.
- As a relatively poor population living in LA, they will express need for housing and food, and will use them to supplement existing resources.
- Of all the populations infected, they already have the networks to use enhancement services such as buddy support.
- They live primarily in the Metro SPA and the surrounding SPAs to the north and west. A significant subset also lives in the South Bay- Long Beach SPA.
- They have successfully cut the infection rates in their community, but due to the length and progression of their illnesses, are more likely to need services in the primary health care core, including outpatient care, specialty care, oral health and treatment adherence.
- As experienced users of services, they are less likely to need patient care coordination.
- The high risk of infection and re-infection makes risky behavior, exacerbated by non-injection use of "party drugs" and alcohol, all the more serious and challenges models that allow risky behavior between those already infected.

A second epidemic is accelerating among the more recently infected, who are also much more likely to be people of color. Latinos represent the largest numbers, but African Americans, with just under 9% of the population, represent 22% of PLWA and 31% of PLWH.

- Latinos represent 46% of the general population in Los Angeles County, and between 20% and 65% of the general population in each SPA. They represent 37% of PLWA and 44% of PLWH. With the exception of SPA 7, the proportion living with HIV/AIDS is less than their proportion in the population.
- African Americans are clustered in SPA 6, South (35%) and SPA 8, South Bay-Long Beach (13%). In the South SPA they represent 57% of PLWA and 61% of PLWH. In South Bay-Long Beach they represent 26% of PLWA and 31% of PLWH.
- People in this group who are newly infected tend to be poorer and have serious co-morbidities, including substance use, mental illness, homelessness and poverty.
- Newly infected, particularly Latinos, are much more likely (49%) to have no insurance and, even if eligible for benefits, many need help applying for/accessing those services.
- The newly infected will need client advocacy – defined in this continuum as assistance obtaining financial and other benefits.
- African Americans and the undocumented are much less likely to have a work history that qualifies them for Medicare.
- As more newly infected, those who are following a pharmaceutical regimen are less likely to progress to AIDS, and are, thus, unable to qualify for disability and the MediCal and Medicare benefits that arise from being disabled.
- Because a much higher proportion of the recently infected are accessing CARE Act-funded services, a larger proportion of PLWH will need CARE Act-funded services.

- Given their higher level of poverty, they are more likely to express a need for food, hosing, and transportation than those in the more mature epidemic – much of the need which currently goes unmet.
- Given that many have little experience with ongoing health care and a significant minority are not native English speakers, they are more likely to need services provided under patient care coordination, including case management, translation/interpretation and referrals.
- Particularly among the African Americans, many are challenged by the difficult drug regimens and need (whether it is expressed or not) treatment adherence assistance.
- The recently incarcerated are more likely to fall in this group, and are among the highest need population. They are much more likely to be homeless and substance users. As they transition out of incarceration facilities, they may loose contact with providers and be confronted with issues that make AIDS care and treatment a lesser priority. There is a critical period of transition when it is important that they receive intensive case management to keep them in care.

A third emerging epidemic is among young gay men – particularly young gay men of color. They have many of the characteristics of the newly infected, but are further burdened by discrimination in their communities, and are much less likely to have community support for accessing care.

- They are more likely to live in the SPA 4 Metro, as well as SPA 6 South, and SPA 7 East.
- Often still uncomfortable with their sexuality, many of them do not get tested for HIV. Those tested are more likely to remain out of care until experiencing symptoms.
- Fortunately, there are networks that are being activated to bring them culturally competent care.

Although there is little supportive empirical data, the undocumented may represent a hidden epidemic in Los Angeles.

- At significant risk, they are much less likely to seek or be in services.
- Women, particularly, may avoid care because of significant barriers (such as stigma) preventing them from accessing care. Accordingly, they might be targeted for specialized service:
    - Transportation and child care (under Removal of Barriers),
    - Translation and interpretation (under Patient Care Coordination), and
    - Legal services (under Economic Well-Being).

IDUs and MSM/IDU are populations that represent under 20% of the epidemic.

- They are comprised in both the mature epidemic, as PWLA, and also among the more recently infected.
- Given their high acuity scores--due to the high incidence of homelessness, mental illness and poverty--they are more likely to have a need for a disproportionate amount of CARE Act-funded services.

- Often unwilling or unable to control their substance use, they face particularly high barriers in accessing and maintaining care. In the focus groups, the reason for not seeking care or falling out of care is often drug use.

A small, but high need population is transgender people living with HIV/AIDS. With much higher infection rates than other populations, they are more likely to be diagnosed with AIDS. Although there have been some efforts to reach the transgender community through special programs, they tend to be low-income and face considerable barriers to accessing care.

Goals And Objectives

The Comprehensive Care Plan addresses the needs of the mature, newly infected and special populations through several initiatives with a goal of maintaining a high level of care while, at the same time, making it more efficient and better targeted to those in need.

The mission is clear:

- Increase the points of entry into the care system;
- Improved integration and coordination of services in the continuum of care;
- Maximizing the use of CARE Act funds;
- Employing technological and other advances to bring efficiency to the delivery system; and
- Empowering PLWH/A.

The theme of increasing access points leads to further regionalization of planning and service delivery by SPA. By empowering PLWH/A as local planners and coordinating care within and between SPAs, the outcome will increase community awareness and participation in HIV/AIDS care and treatment. Embedded in this effort is the activation of Consumer Advisory Boards that involve PLWH/A in the process of ascertaining needs and gives them a powerful voice in the planning process.

Integration and coordination of services are impossible without an overall view of how the care system works. The Commission has adopted a continuum of care that provides that overview, with a mandate that services produce positive health outcomes and reduced mortality, morbidity, and improved adherence and quality of life.

The continuum has significant implications for the integration of prevention and care services, contracting services and monitoring outcomes. Medical care is at the core of primary health services because of the strong relationship between medical care and decreased mortality and morbidity. Surrounding medical care are patient care coordination, activities to remove barriers, and to enhance economic well-being. The purpose of these services is to ensure that every client has access to medical and primary health care services. Enhancement services similarly have to show that they contribute to PLWH/A accessing the primary health care core and improve the quality of life of PLWH/A.

A second key factor in improved integration of services is sharing client information. This will be accomplished through automated client-level tracking systems where providers have common

intake forms, eligibility criteria, service protocols and outcome measures. There are several initiatives that enhance current client reporting and, by 2005, including a new web-enabled, real-time data management system. Recognizing that these changes will affect the work flow and incorporate new practices, the Comprehensive Care Plan recommends several types of training that will allow provider staff to understand and implement the systems and procedures effectively.

The Plan also recognizes the need to bring the newly diagnosed into early intervention services, and there is both a new tracking system tool (HITS) proposed and accompanying training to assure this process is understood. The launch of statewide HIV reporting makes the tracking of HIV+ people and follow-up with their social network affiliation possible, and the tracking of PLWH allows providers to remind those not accessing care of its importance.

Admittedly, adoption and integration of the Continuum of Care and its corresponding systems is likely to extend beyond the expertise of many providers. For that reason, capacity building is a necessary service to be made increasingly available to ASOs. Technical assistance is also made available to help improve the ability of providers to access alternative sources of reimbursement. To assist providers, a technical assistance clearinghouse has been envisioned to help agencies identify resources and experts that can assist them with infrastructure or program development.

Maximizing the use of CARE Act funds is necessary given that the per capita expenditure is declining. As a result, several objectives encourage and/or mandate that providers assist PLWH/A access non-CARE Act benefits if they are eligible. Particular emphasis has been focused on moving clients into the MediCal, Emergency MediCal (for the undocumented), Medicare, CHIP and other programs that reimburse providers for similar services. Key to this effort is standardizing eligibility criteria and automating the process to highlight eligibility for CARE Act funds or other funding sources.

Maximizing the use of CARE Act funds also means the efficient management of funds and planning services to meet the needs and unmet needs of PLWH/A. One of the major initiatives in the Comprehensive Care Plan requires restructuring of the Commission's staff support. By providing a professional support staff for the Commission, OAPP can focus on implementing Commission directives and its administrative agency responsibilities, and the Commission can move forward in its planning process without being burdened by the bureaucratic quagmire that has stymied past Commission planning efforts.

To maximize funds and accountability, the Comprehensive Care Plan also calls for a gradual move to unit costing and fee-for-service reimbursements, starting with requested rate, fee, and reimbursement review.

In this process there will be a re-calibration of the needs assessment process that should allow OAPP adequate time to incorporate findings into a proactive plan for designing and evaluating the continuum of care. It recommends moving the next full planning process into 2004, with updates starting immediately.

In maximizing Ryan White CARE Act funds, the Comprehensive CARE Plan further recommends community education and public advocacy to promote public awareness of the increasing impact of the epidemic, greater number of persons in care, and decreasing per capita allocations through public funds. The initiative also suggests resources be allocated to educate legislators about legislation that would bring additional funds and services to PLWH/A.

To ensure that there is both outcome and program assessment, the Comprehensive Care Plan calls for several services to be evaluated on their own merits, and then compare them to other EMAs in a series of best practices studies. In this way, programs can benefit from lessons learned in other settings and their own strengths (and weaknesses) can be documented and used to update, modify and make programs more responsive to the needs of PLWH/A.

Meeting Needs and Filling Gaps

In the plan, the needs assessment and epidemiological information is used to justify needed services. Highlights include:

- Targeting highly vulnerable populations such as African Americans and young gay men for intensive primary medial care and adherence services.
- Ensuring adequate capacity to meet the increasing needs of Latinos living with HIV/AIDS.
- Using standard intake and acuity scaling to determine service needs.
- Developing individual and family service plans.
- Designing specialized mental health services for transgender persons.
- Offering family mental health services that will increase family support for PLWH/A.
- Assuring that specialty medical services are accessible.
- Addressing the unmet oral health needs while providing technical assistance to access other funding sources for dental care.
- Linking nutritional counseling to medical and case management visits.
- Emphasizing treatment adherence services and adopting best practices models that have been proved successful in increasing adherence.
- Integrating CARE Act-funded substance abuse services into the general substance abuse services.
- Limiting home health care to those who truly need it based on acuity and lack of access to home health care funded by other services.
- Increasing the distribution of food vouchers, but offering them within the context of medical and case management services.
- Improving coordination and client advocacy with HOPWA in order to move those in short-term into long-term housing.
- Providing medical and mental health services on-site in transitional housing.
- Prioritizing transportation services for those traveling to medical services and benefits appointments.
- Funding client advocacy to help clients secure alternate benefits.

- Beginning to use medical case management during medical visits.
- Tracking and maintaining recently diagnosed clients from counseling and testing into the continuum of care smoothly and efficiently, with a special focus on those who fall out of care.
- Revisit the need for peer and paraprofessional support and measure its success in enhancing quality of life and/or increasing adherence to medical regimens.

The Plan is a living document that provides a blueprint to achieving the HIV/AIDS service system's mission, vision and values. After more than 20 years of confronting the epidemic, HIV/AIDS continues to be a major health concern. The news from the recent International AIDS Conference (July 2002) in Barcelona, Spain, regarding vaccines was not optimistic. This Plan commits the Commission to build the infrastructure that will permit a new level of integration and care for the next decade, while adopting near-term practices that will maintain and improve HIV/AIDS care services for all populations infected and affected by HIV/AIDS in Los Angeles County.

INTRODUCTION

The Los Angeles County HIV/AIDS Comprehensive Care Plan (Plan) presents a road map of the County's response to HIV/AIDS epidemic. It focuses on describing the journey made by the Commission on HIV Health Services (Commission) to address the epidemic, while presenting future routes anticipated in its mission of decreasing HIV/AIDS mortality and morbidity, improving the quality and availability of comprehensive HIV/AIDS-related services to needy individuals and families, collaborating with other HIV/AIDS services organizations to assess and identify emerging HIV/AIDS services delivery needs, and facilitating a coordinated and community-based viable regional voice for HIV-impacted populations.

The first section reviews the history of the HIV/AIDS epidemic in Los Angeles County (Los Angeles County). This section:

- Reviews the overall context of the Plan by describing the vision and values of the Commission, and its continuum of HIV/AIDS care.
- Provides an overview of economic, social and health indicators in the LA EMA and its Service Planning Area (SPAs).[1]
- Summarizes the epidemiology of the HIV/AIDS epidemic in Los Angeles County and highlights the diverse linguistic and cultural heritages of the various populations affected by the epidemic, including composites of PLWH/A in each Service Planning Area (SPA). The epidemiology focuses on people living with HIV/AIDS, as this will be the population that must be served by the continuum of HIV/AIDS care.
- Estimates the number of PLWH/A who are not in care.
- Profiles the new infections and discusses trends in the epidemic.
- Describes HIV within a larger fabric of community needs, and discusses how the co-morbidities of drug use, homelessness, STDs, mental illness, and poverty intersect and affect the HIV/AIDS service needs of PLWH/A.
- Summarizes the needs, unmet needs, service gaps, barriers, and disparities to services confronting PLWH/A based on a 2002 needs assessment survey, focus groups and supporting data from a variety of empirical studies and economic analyses. The needs of different ethnic and risk group subpopulations are presented, highlighting the needs and barriers of the eleven target populations[2] and those out-of-care.
- Reviews the services available for PLWH/A in Los Angeles County.
- Provides a service provider profile indicating locations and current utilization of services.

The second section details the route to be traveled to reach the Commission's goals and objectives for HIV/AIDS services in Los Angeles County. This section:

- Summarizes the strategic planning process undertaken by the EMA's Core Planning Partners [the Commission, the Office of AIDS Programs and Policy (OAPP), and the Select Committee on Prevention Planning (PPC)].

[1] The County of Los Angeles is divided into eight Service Planning Areas (SPAs) that are used for health planning purpose. They are discussed throughout the report.

[2] 1) Women of Child bearing age (13-49), 2) Transgender, 3) MSM of Color, 4) Anglo MSM, 5) Intravenous Drug Users (IDU), 6) Non IDU Substance Users, 7) Homeless, 8) Youth (13-24), 9) Undocumented, 10) Chronically mentally ill, 11) Incarcerated and post-incarcerated.

- Outlines core competencies and weaknesses of the care services system.
- Delineates the HIV/AIDS service system's primary goals and objectives for the next three years.
- Proposes how Ryan White CARE Act funds can fill critical gaps in the continuum of care or be used to build bridges to existing services that may meet complementary needs of PLWH/A--such as substance abuse or housing--which need to be more sensitive to the specific needs of PLWH/A.
- Recommends budget priorities and allocations for key services, as well as for systemic program support and planning council (Commission) support.

The final section discusses how the Commission and OAPP will monitor the progress and outcomes of the Comprehensive Care Plan. For each objective, mechanisms to monitor the process and measure outcomes will be detailed. As work continues on the Plan, data sources and indicators will be developed, benchmarks noted where data is available, and if not available, data that is needed for benchmarks and subsequent measurements of progress will be identified. Both quantitative and qualitative measures are discussed.

Methodology

Community / Consumer Forums

This past year, the Commission developed a two-tiered strategy for collecting "expressed need" data, distinguishing between "community forums" and "consumer forums". The community forums were venues open to the general public, including service providers and non-identified PLWH/A, while consumer forums were specifically designed to elicit input from PLWH/A accessing the care services system. The term "Consumer Focus Forum" was used to capture concepts of both consumer forum and a focus group driven by data collection needs. This past year, the community/consumer forum process represented both a research project and a channel for the consumers to express their needs, and 308 PLWH/A participated.

The forums' purpose was geared towards gaining greater insight into consumers' perceptions of needs, gaps, barriers and disparities. Comments extracted from the transcripts of the forums can be found in the companion document "Community Forum Comments: L.A. County PLWH/A Discuss Services and Barriers to Service, July 2002." This companion document details a more thorough methodology, describing recruitment for the forums, and problems and challenges experienced by participants during the process.

All of the consumer forums were held at Ryan White CARE Act (CARE Act)-funded service providers. The sites were chosen based on geographic distribution, space availability, HIV prevalence in the area, and with special attention paid to populations with special needs. For example, more forums were held in SPAs with greater HIV prevalence, such as SPAs 4, 6 and 8. Additionally, agencies that specifically serve communities of color were selected to host forums in order to ensure input from those communities. There were a total of six forums conducted in Spanish, spread throughout areas with large Latino populations [SPAs 4 (Metro), 7 (East), and 6 (South)]; among them was a female-only group. Another focus forum was targeted towards the Asian/Pacific Islander community, hosted by Asian/Pacific Islander AIDS Intervention Team

(APAIT). Other forums targeting other populations with special needs included an agency specializing in services for the transgender community (Bienestar) and an English-speaking female-only forum. Table 1-1 lists the forums that were held by SPA and host provider.

Table 1-1 Community & Consumer Forums

#	Date	SPA	Host Provider	Sessions Scheduled	Sessions Occurred	Participants
1	4/22/2002	2	Olive View Hospital	2	2	9
2	4/23/2002	2	Valley Community Clinic	2	1	5
3	4/23/2002	7	Los Angeles County/USC 5P21 (Maternal/Child Clinic) – *Spanish*	2	1	21
4	4/24/2002	1	Catalyst Foundation	2	1	13
5	4/24/2002	7	Los Angeles County/USC 5P21 (Maternal/Child Clinic) – *women, Spanish*	2	1	15
6	4/24/2002	4	Asian/Pacific Islander AIDS Intervention Team – *API*	2	1	22
7	4/24/2002	4	AIDS Project Los Angeles West	2	1	4
8	4/25/2002	6	Minority AIDS Project	2	2	28
9	4/25/2002	3	AIDS Service Center	2	2	37
10	4/25/2002	4	Bienestar (Hollywood)	2	2	8
11	4/25/2002	4	Los Angeles County/USC 5P21 - *women*	2	2	22
12	4/25/2002	3	Foothill AIDS Project	2	2	11
13	4/26/2002	3	East Valley Community Health Center	2	1	15
14	4/29/2002	8	Harbor UCLA	2	1	2
15	4/30/02	5	UCLA Care Center	2	0	0
16	4/30/2002	6	Charles Drew University	2	2	17
17	4/30/2002	6	Watts Healthcare Foundation	1	1	12
18	4/30/2002	8	St. Mary CARE Clinic	2	2	21
21	4/30/2002	7	AltaMed - *Spanish*	2	1	13
22	5/1/2002	4	JWCH/LA Shanti	2	1	6
23	5/2/2002	7	Whittier-Rio Hondo AIDS Project	2	1	9
24	5/2/2002	4	West Hollywood/Plummer Park	1	0	0
25	7/19/2002	5	Common Ground	1	1	12
26	7/22/2002	4	AIDS Project Los Angeles West – *nutrition*	1	1	6
TOTAL				42	30	308

Key Informant Interviews

Key informant, or one-on-one, interviews were conducted to include smaller populations in the qualitative data collection process. Five key informant interviews were conducted with transgender persons identified by staff at Bienestar. The focus group outline was used as a guide in conducting the key informant interviews, each of which lasted approximately 30-45 minutes.

There was also an attempt to locate and recruit Native American PLWH/A. The absence of any care service site that serves primarily Native Americans or has a large clientele of that population made it difficult to identify any participants. Native Americans identified were not able to be reached for interviews. Given the concern for confidentiality among Native Americans, phone interviews were also considered as an option, but still did not result in any interviews with Native American PLWH/A.

Consumer Survey

A survey instrument was designed and approved in mid-April 2002. PCH submitted the draft and several rounds of revisions followed, based on pre-testing in the field. The final consumer survey is shown in Attachment 1. The first section of the questionnaire captures key demographics, insurance and benefits information, levels of care, stages HIV disease progression, medications and adherence, and quality of life indicators. Question 38 measures current need, demand, and utilization of services. The list of services developed by the research team was derived from the continuum of care and includes the seven funded service priorities and the 33 service categories that are funded, or of interest, in Los Angeles County.

Interviewing was typically conducted at the site of the community/consumer forum before or after the scheduled forum. In some instances, interviews were conducted by telephone. Bilingual interviewers administered Spanish-language questionnaires. Out of the 80 surveys administered to Latinos, 40 were conducted with the Spanish-language instrument. In addition to interviewing at the forums, 25 "intercept" interviews were conducted over the course of three days at two of AIDS Project Los Angeles (APLA)'s food bank locations (the main site and the new APLA West location) to interview Anglo MSM.

A total of 262 surveys were administered with 15 of those being returned as incomplete and not usable for data analysis.

Data Sources

In addition to the consumer forum questionnaires and the forum discussion groups, various data sources were referenced, reviewed and interpreted for this report. The primary sources of data used in the report are the HARS (HIV/AIDS Reporting System) database which was used to discussed AIDS trends and current epidemiology of PLWH/A. The SHAS (Supplemental HIV/AIDS Study) database was used to enhance the demographic findings in HARS and to describe the specific service needs of PLWA. The OAPP service utilization data collection system with over 19,100 cases is a critical source for the presentation of demographic trends and service utilization of PLWH/A in Los Angeles County. In addition, several secondary sources and publication were reviewed and these can be seen in Attachment 2.

1. WHERE ARE WE NOW

MISSION OF THE COMMISSION

To achieve the Commission's vision, its mission is to provide effective planning and evaluation of Los Angeles County's HIV/AIDS services delivery systems that improves PLWH/A health outcomes and quality of life in compliance with the Health Resources and Services Administration (HRSA) planning requirements. The Commission's work is intended to comply with Ryan White CARE Act legislative requirements.

VISION AND VALUES OF THE COMMISSION

The shared vision of the Commission is an HIV/AIDS Continuum of Care that will assure 100% access to health care with 0% disparities among the populations infected and affected by HIV and AIDS. This will be accomplished through:

- Multiple points of entry for clients to gain access to services with an expectation that, regardless of entry point, the client will be assessed for need of primary health care core services and referred to needed resources in a timely manner.
- Improved integration, coordination, collaboration, and outreach between and among all care and prevention service providers in both urban and rural areas of Los Angeles County.
- Maximizing Ryan White CARE Act funds through uniform intake and eligibility screening processes and the subsequent coordination of care for PLWH/A that maximizes non-emergency funds for providing quality and sustained HIV/AIDS care.
- Reducing barriers to care, therein empowering PLWH/A to seek and access HIV/AIDS prevention and care services without impediment of structural, language, literacy and/or cultural disparities.

Several values guide the vision and mission of the Commission and its implementation of the HIV/AIDS Comprehensive Care Plan. They include:

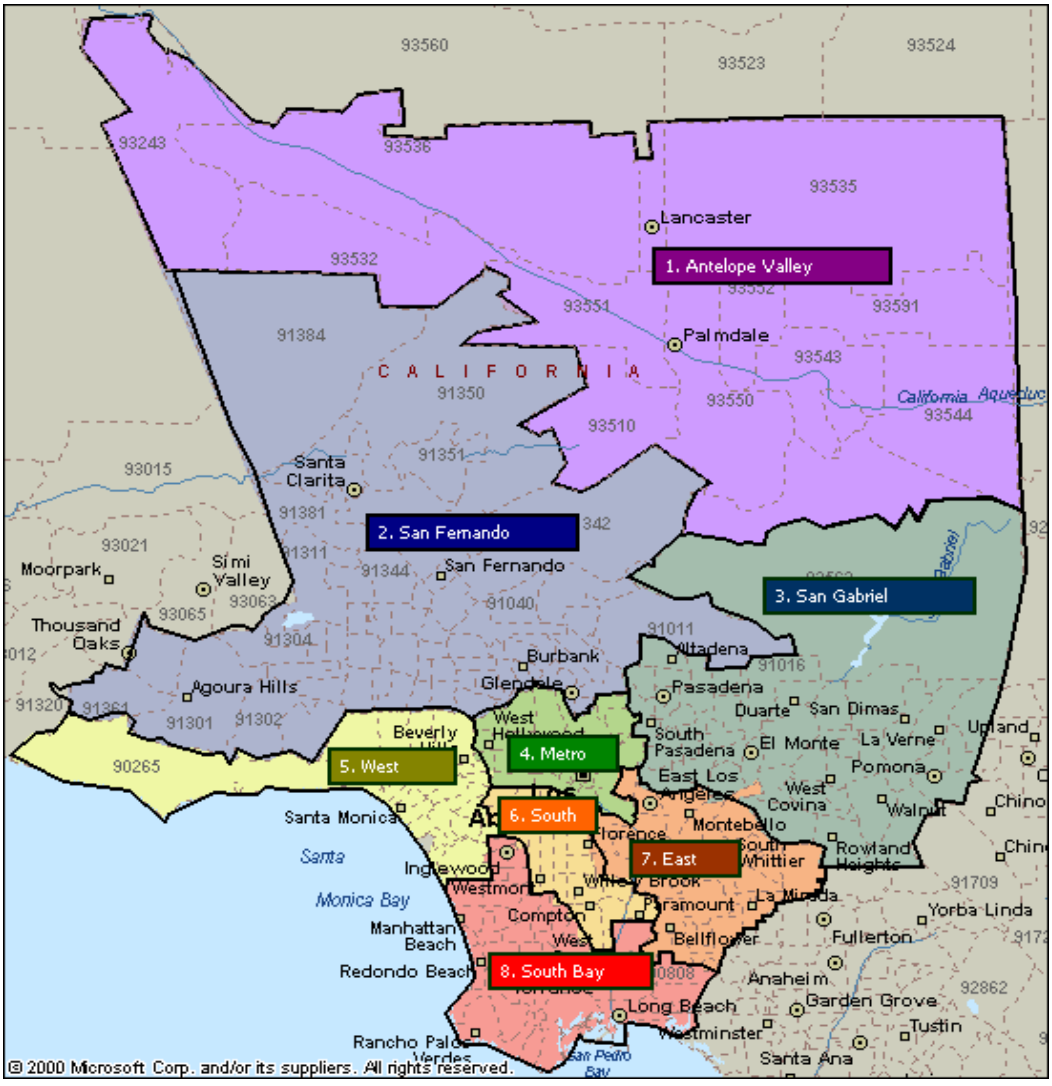
- Services should be accessible to all PLWH/A, along with assurances that those who are eligible can receive CARE Act-funded care.
- Availability of services should be based on need, not the ability to pay.
- Services should be available throughout Los Angeles County.
- Culturally and linguistically appropriate services should be available to the diverse populations of PLWH/A in Los Angeles County.
- Client-focused programming should assure that services meet the needs of clients.
- Services should be compassionately delivered.
- Ethical practices should guide the funding and delivery of services.
- Resources should be fairly and equitably distributed throughout Los Angeles County.
- Services should be delivered to PLWH/A in a respectful manner, attentive to the dignity of every client.
- Services should be cost-effective and cost-efficient.
- Los Angeles County's HIV/AIDS continuum of care should be characterized by innovative, high quality service delivery that improves the health status and quality of life of PLWH/A.

Regional Planning

Creating and supporting multiple service entry points and providing accessible services to all PLWH/A is an integral part of the Commission's mission and values. Consequently, the Commission is committed to providing services on a regional basis.

In 1996, eight Service Planning Areas (SPAs) were created within Los Angeles County, each with a Coordinating Council that collects and analyzes local data, and coordinates services accordingly (Figure 1-1). These SPAs have been widely adopted and are now used by most County departments and other service organizations to facilitate planning. The Commission has adopted the SPA as the major unit for HIV/AIDS health care planning. A brief geographic description of each area is provided in Attachment 3. Throughout this Plan, data is presented on an aggregate County level and, when possible, by SPA.

Figure 1-1 SPA Map



CONTINUUM OF CARE

The Commission adopted a new continuum of care in 2001 and has continued to modify and improve it throughout 2002. The visual representation of the model accepted by the Commission in 2001 is shown in Figure 1-2. Conceptually, the continuum is composed of a core of primary health services that are essential to improving health outcomes through the delivery of primary physical and emotional health care, including medical outpatient services, dental care, nutritional counseling, mental health services, substance abuse services, end-stage hospice care and patient education, counseling and testing, health education/risk reduction activities, treatment adherence services, and prevention efforts. The continuum recognizes that in order to sustain improved health outcomes, each of these types of services comprise a critical component of primary health care.

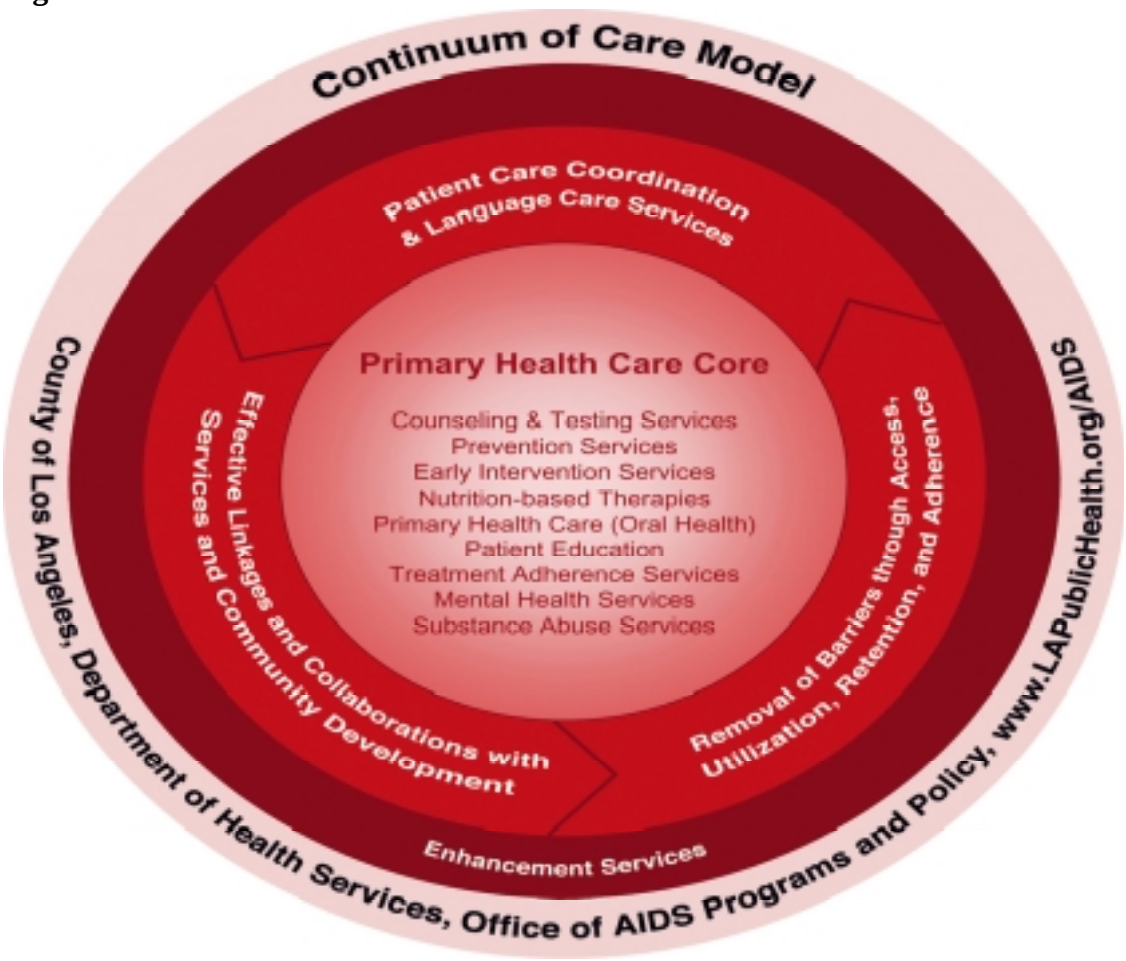
The core is surrounded by "wrap-around" services clustered according to the following sets of services:

- Removal of Barriers Services that optimize "critical paths" through access, utilization, retention, adherence, transportation, child care, housing, food services, psychosocial case management, and client advocacy. These key services provide low-income PLWH/A access to care which meets their basic needs and that allow them to focus on their HIV primary health care. Studies have shown that PLWH/A who do not have their basic housing and nutritional needs met, or who have no or poor transportation to services, are unlikely to seek and maintain primary health care.
- Patient Care Coordination and Language Services offer PLWH/A a choice in care coordination approaches (patient care coordinators, nurse case managers, medical case management, etc.) and language services for non- or limited English proficiency populations. Patient care coordination services respond to the complexity of the health care system and by providing expert guidance in to clients seeking and accessing services provided in the continuum of care. Case management is viewed as critical to assisting PLWH/A obtain and maintain their proper regimens of care. For those who do not speak English or who experience difficulties with English comprehension, translation and interpretation services are an essential factor in patient care coordination.
- Economic Well-Being Services that create direct, working, effective linkages and collaborations with services and community developments related to amelioration of poverty, workforce re-entry services, health insurance (and other benefits) access and continuation of services. Economic well-being measures include legal services and permanency planning. Both of these types of services significantly impact the continuity of care for families, in particular addressing the needs of HIV-positive and -negative children of parents who are HIV+.

The third tier of services, "self-enhancement", are designed to enhance the core and wrap-around services, and the quality of life for PLWH/AIDS. The wrap-around and self-enhancement services are intended to mitigate disparities in care and ensure client access to appropriate primary health care services. Self-enhancement services improve clients' quality of life through activities such as self-help services, peer support, buddy companion services and pastoral care.

Not shown in Figure 1-2 are program support and planning council support, although these are included in the description of the continuum of care.

Figure 1-2 Continuum of Care

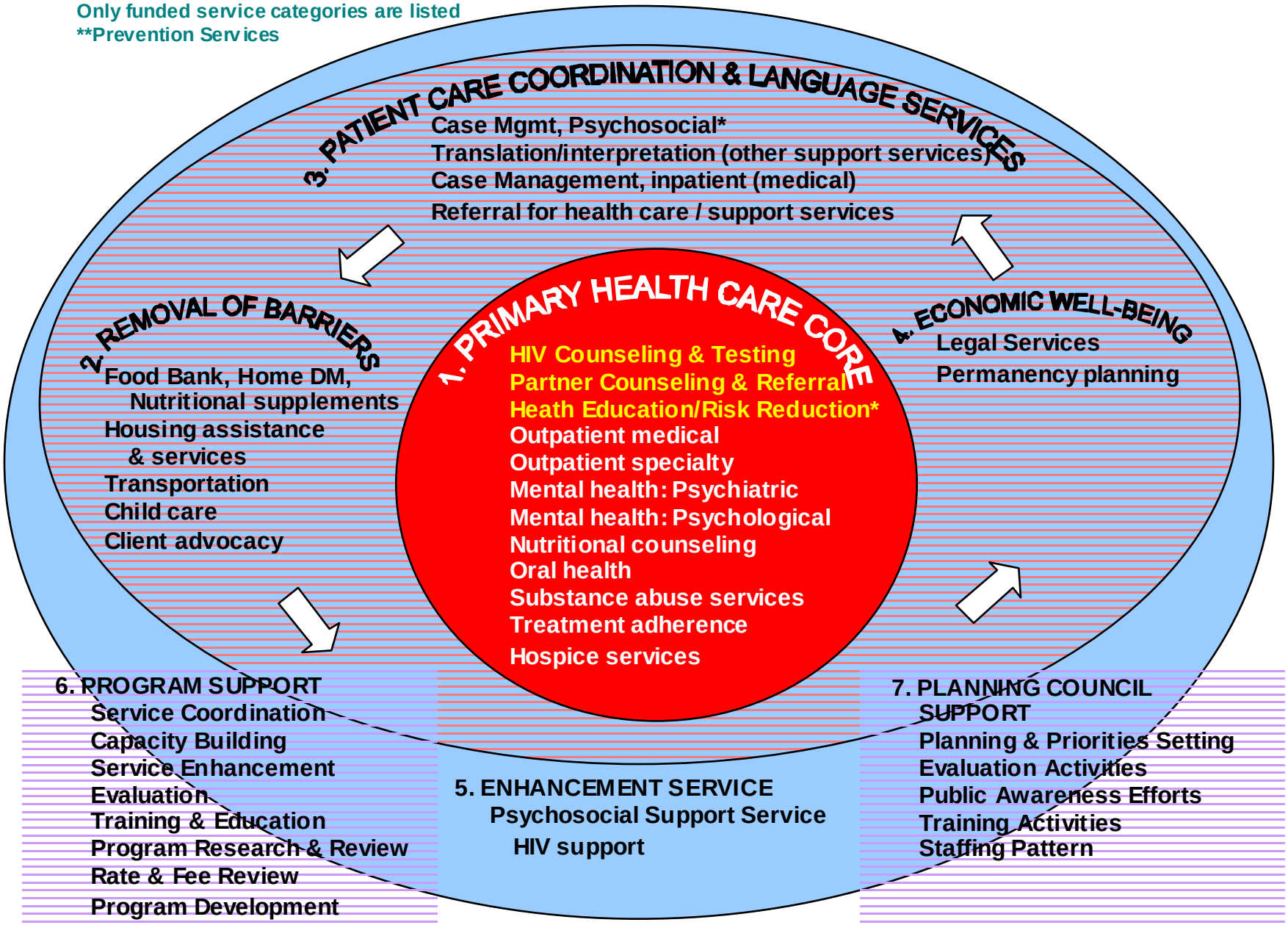


The Commission's Priorities & Planning (P&P) Committee of the Commission recommended further refinements on the model and priority of services, which were approved by the Commission on July 23, 2002. The changes were:

- Changes in priorities, ranking the Removal of Barriers as the second priority, Patient Care Coordination the third, and Economic Well-Being the fourth. This was in response to the high demand for these services such as housing, food, and transportation expressed by PLWH/A, and the recognition that barriers still prevent clients from accessing primary health care—even if they are receiving cohesive patient care coordination services.
- Combining psychosocial and medical case management in the same priority, Patient Care Coordination as parts of the larger goal of service and client coordination, making that one of the Commission's primary goals.

The recommended model with the funded services for 2003 is shown in Figure 1-3. This model lists only Prevention and CARE Act-funded services. All services in the continuum, and their priority ranking by the Commission for 2003 are detailed in Table 1-1.

Figure 1-3 Recommended Revised Continuum of Care Model
County of Los Angeles, Department of Health Services, Office of AIDS Programs and Policy, www.LAPublicHealth.org/AIDS



In order to manage the continuum of care, program support assures that there is a system-wide program and evaluation infrastructure in place to coordinate services, build capacity, measure outcomes, assess programs and provide the necessary training, education and technical assistance to providers and consumers facilitating consumer access and ensuring high quality of care.

In addition to it comprehensive plan responsibilities, the Commission is required to address and execute its legislatively mandated priority- and allocation-setting responsibilities and to ensure that the process of distributing service funding is performed equitably. Further, the Commission is charged with assessing the administrative mechanism, establishing a system-wide grievance procedure, evaluating service effectiveness, and educating consumers and the public on the availability of HIV/AIDS services and opportunities to participate in the planning process.

As demonstrated in Table 1-1, several types of services are not funded by the Commission because they are either funded elsewhere and/or are a low-priority service. These priority and allocation decisions are based on the findings in the needs assessment and other data considered by the Commission. These decisions are discussed in the following sections.

Table 1-1 Continuum of Care Services by Ranking and Priority

("F"=CARE Act Title I/II-funded; "O"=Other funding; "N"=Non-funded)

PRIORITY	SERVICE CATEGORY	ALLOCATION
#1	Primary Health Care Core	
high	Prevention services	O
high	Ambulatory/outpatient medical services, preventive care and screening	O
high	Ambulatory/outpatient medical services, early intervention	O
high	Ambulatory/outpatient medical services, patient education	O
high	Ambulatory/outpatient medical services, medical	F
high	Ambulatory/outpatient medical services, specialty	F
high	Drug reimbursement, State ADAP	O
high	Home health, professional care	O
high	Mental health services, psychiatric	F
high	Mental health services, psychological	F
high	Nutritional counseling	F
high	Oral health care	F
high	Substance abuse services (outpatient and residential)	F
high	Treatment adherence services	F
med	Drug reimbursement, medications	O
med	Health education/risk reduction	O
med	Home health, specialized care	O
med	Rehabilitation services	O
low	Drug reimbursement, local	O
low	Inpatient personnel costs	O
low	Residential or in-home hospice	F
#2	**Removal of Barriers**	
high	Food bank/home delivered meals/nutritional supplements	F
high	Housing assistance/housing services	F
high	Transportation services	F
high	Emergency financial assistance	O
med	Child care services	F
med	Client advocacy	F
med	Outreach services	O
#3	**Patient Care Coordination**	
high	Case management, psychosocial	F
high	Housing related services	O
high	Translation/interpretation (other support services)	F
low	Case management, inpatient (medical)	F
low	Referral for health care/supportive services	F
#4	**Economic Well-Being Measures**	
med	Health insurance	O
med	Legal services	F
med	Workforce entry/re-entry	O
low	Child welfare services, family preservation/unification	O
low	Child welfare services, foster care	O
low	Permanency planning	F
#5	**Enhancement Service Options**	
med	Psychosocial support services, HIV support (lay and peer counselors / peer support)	F
med	Psychosocial support services, pastoral care	N
low	Psychosocial support services, child abuse/neglect counseling	O
low	Child welfare services, parenting education	O
low	Buddy/companion service	O
low	Development assessment/children and infants	O
low	Day/respite care/adults	O
low	Home health, para-professional care	O
low	Psychosocial support services, alternative services	O
low	Psychosocial support services, recreational outings	O
low	Psychosocial support services, caregiver support	O
low	Psychosocial support services, bereavement counseling	O

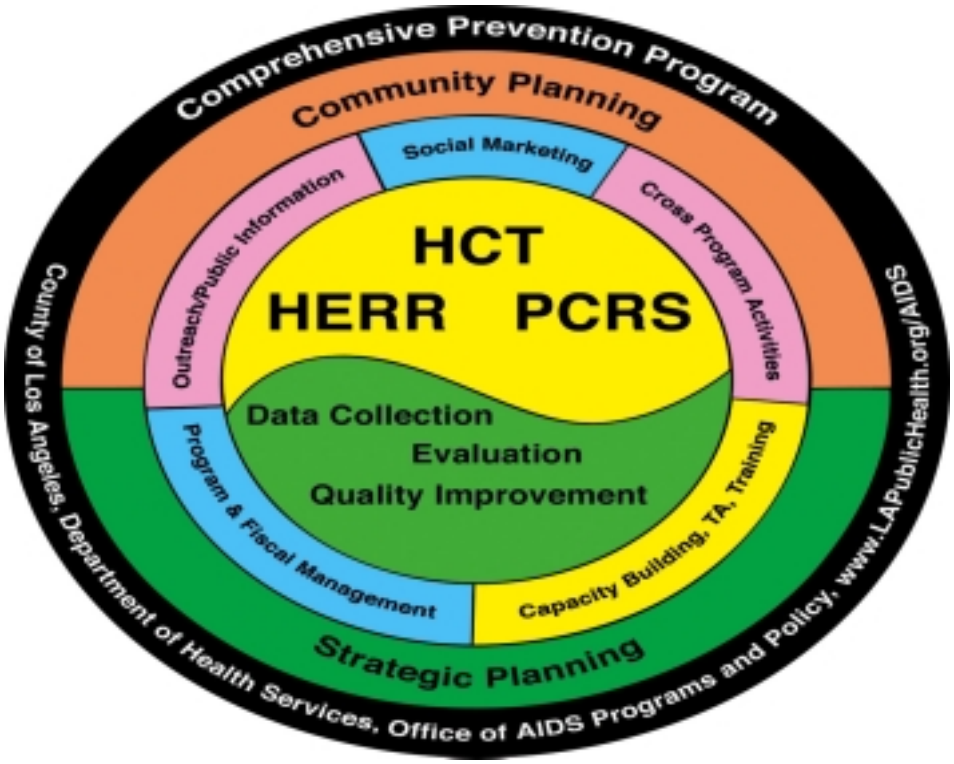
Interface with Comprehensive Prevention Program

The HIV Care Continuum of Care incorporates prevention in the Primary Health Care Core. As shown in Figure 1-4, the Prevention Planning Committee (PPC) has developed a comprehensive prevention program. Over the next two years, the Commission will continue its efforts to integrate the PPC Comprehensive Prevention Program into the Continuum of Care. For example, a major initiative to link care with HIV Counseling and Testing (HCT) services is currently planned, and discussed under "Where We Are Going", later in the Plan.

Other opportunities for linkages include educational efforts at care sites, as evidenced by the Commission's decision to include patient education in the first priority, Primary Health Care, of the Continuum of Care. The need is apparent with the recent findings that re-infection can have serious negative outcomes for PLWH/A. Primary and secondary prevention messages are especially important among substance users, the homeless and others with co-morbid conditions where health education and risk reduction might improve stability and access to care.

With California's launch of HIV reporting in July, 2003, there is now an enhanced opportunity for EMAs to develop seamless client services databases that include those testing and being reported as positive; the Los Angeles County EMA has already begun initiating several of those efforts. The Commission and the PPC will also join efforts in the development of mutually-beneficial quality improvement and evaluation tools.

Figure 1-4 Comprehensive Prevention Program



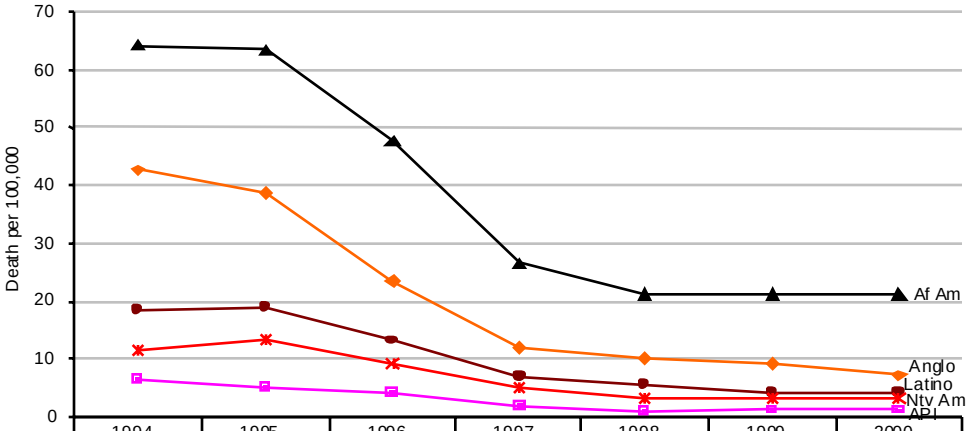
OUTCOMES

To assess the success of a continuum of care, medical and social outcomes must be measured and tracked. Basic outcomes for the HIV/AIDS continuum of care are mortality, morbidity, and quality of life.

Mortality: Death Rates and Case-Fatality Rates

The mortality figures suggest that the care system is working for the vast majority of PLWH/A. All subpopulations are living longer. However, the decline in death rates and death rate at the end of 2000 is not equal among all racial/ethnic communities. As shown in Figure 1-5 the death rate (defined by the crude death rate per 100,000)[3] has declined slower and is substantially higher among the African American population. The rate of decline for African Americans has been about 67% between 1994 and 2000, compared to a decline of over 80% for Anglos and APIs and 78% for Latinos. Since 1998 death rates have leveled off for all racial and ethnic populations, but African American death rate continues to be three to five times than Anglo and Latino death rates. The higher rates among Anglos and African Americans show, in part, the higher rate of new infections among these populations. The higher death rate for African Americans is indicative of the disproportionate impact of HIV/AIDS in the African American community, and the continuing high number of new cases. While African Americans account for 9% of the Los Angeles County population, they account for 22% of all PLWA, with a prevalence rate of 425 cases per 100,000, compared to a rate of 197 and 136 per 100,000 among Anglos and Latinos, respectively.

Figure 1-5 HIV/AIDS Deaths by Ethnicity per 100,000 of L.A. EMA Population



	1994	1995	1996	1997	1998	1999	2000
Af Am	64	63	48	26	21	21	21
Anglo	43	39	23	12	10	9	7
API	7	5	4	2	1	1	1
Latino	18	19	13	7	5	4	4
Ntv Am/Alaskan	11	13	9	5	3	3	3

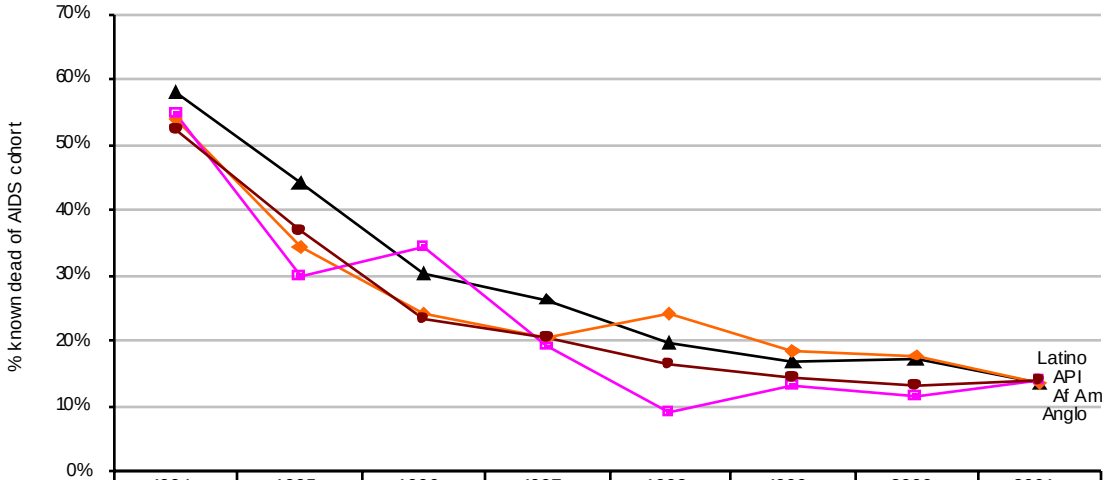
[3] The mortality rate, or rate of death per 100,000 reflects everyone who was recorded by a doctor on the death certificate as dying of AIDS-related disease for a specific year. The mortality rate captures trends in current deaths due to AIDS, whether or not they were ever reported to HARS as a person with AIDS and regardless of when they were diagnosed. At the time of this Plan, only data through 2000 was available from the Department of Vital Statistics.

TOTAL for above pops	143	139	97	52	40	38	36

The large discrepancy in death rates between African Americans and other ethnic populations is somewhat moderated by examining the fatality rates shown in Figure 1-6. This "case-fatality rate" measures the death rate among the cohort diagnosed with AIDS during a certain calendar year. While death rates show the disproportionate impact of AIDS on the African American community, the case fatality rates show the survival rate once a person is diagnosed with AIDS and accesses the care system. For more recently diagnosed cases receiving current medication and care, it would be expected that case fatality rates would decline. Differences in case fatality by ethnic groups could indicate a disparity in service.

As shown in Figure 1-6, fatality rates have declined among all ethnic groups at about the same pace, going from about a 50% case-fatality rate in 1994 to less than 15% in 2001. In 1998, APIs and Latinos had the lowest fatality rates, but by 2001 the rate among African Americans and Anglos dropped below both the APIs and the Latinos. The small difference in case-fatality rates among ethnic populations suggests that while African Americans are disproportionately diagnosed with AIDS and die at a higher rate, once diagnosed with AIDS, African Americans, Latinos, APIs and Anglos are all surviving at about the same rate. Through 1997 nationally, the last date of available case-fatality rates for the US, Los Angeles case-fatality rates exceeded national rates, and through 1999, Los Angeles rates for all groups exceeded the average rate for California.

Figure 1-6 Case-Fatality Rates



	1994	1995	1996	1997	1998	1999	2000	2001
Af Am	58.1%	44.0%	30.3%	26.2%	19.5%	16.6%	17.1%	13.3%
Anglo	53.8%	34.4%	24.3%	20.3%	24.0%	18.1%	17.7%	13.1%
API	54.7%	30.0%	34.4%	18.9%	8.9%	13.0%	11.5%	13.9%
Latino	52.2%	36.7%	23.5%	20.6%	16.4%	14.3%	12.9%	14.1%

Progression from HIV to AIDS

In addition to declining death rates, early treatment of HIV disease should greatly reduce the progression of HIV to AIDS. In 1994, 3,672 persons were diagnosed with AIDS in

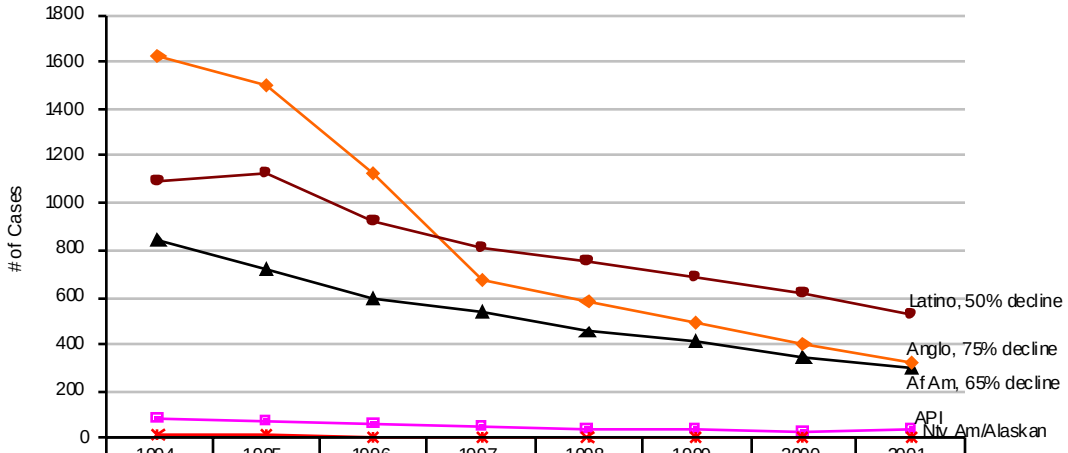
the Los Angeles EMA, while in 2001, less than half of that amount, 1,193 persons were diagnosed, representing a decline of about 70%.

New AIDS Cases by Ethnic Populations

Figure 1-7 shows that while there has been a consistent decline in newly diagnosed cases from 1994 to 2001, not all ethnic populations have followed the same pattern. For instance, since 1994 the AIDS rate among Anglos has declined more than 75% while the decline among communities of color has been smaller, with a decline of 65% among African Americans, 58% among API, 52% among Latinos, and 41% among Native Americans. Furthermore, in 2000, the AIDS rate among African Americans (41 per 100,000) was over four times the rate among Native Americans (9), nearly three times that of Latinos (14) and Anglos (13), and well over 20 times the rate among APIs (2 per 100,000).

In terms of absolute numbers needing services, the growing Latino population represents about 50% of the Los Angeles County population in 2001 and represents 44% of the newly diagnosed cases in 2001. While they are not disproportionately impacted by AIDS, they will continue to contribute the largest number of HIV cases over the next several years and their decline in the number of newly diagnosed cases is lower than either Anglos or African Americans. Anglos, with 33% of the population, have the next largest number of newly diagnosed cases, although they have fallen below the number of Latinos. African Americans while only 9% of the total county population, account for almost one quarter of the newly diagnosed cases. In planning services for the newly diagnosed, the most units of service have to be allocated for the Latinos living with HIV and AIDS. At the same time, the system has to prepare for a rapidly growing number of African Americans living with HIV and AIDS.

Figure 1-7 AIDS Cases by Year of Diagnosis by Race



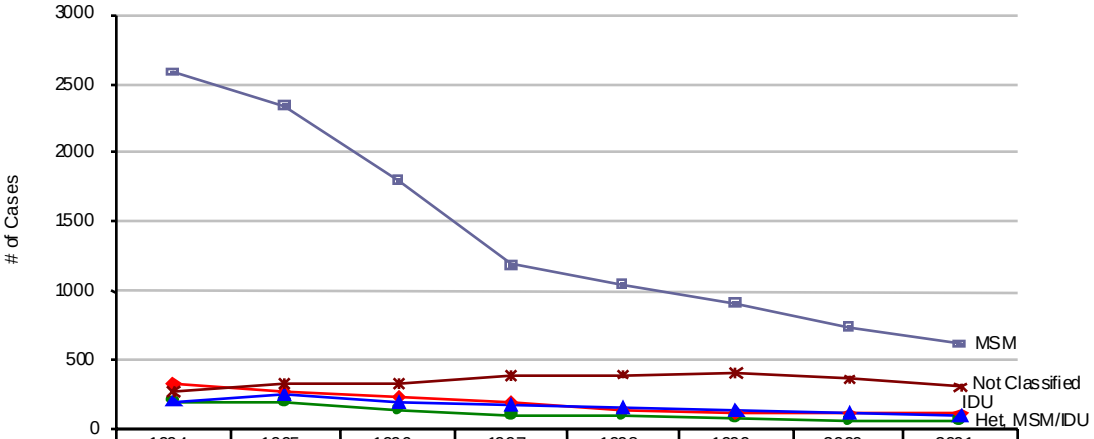
	1994	1995	1996	1997	1998	1999	2000	2001
Af Am	844	723	595	542	456	421	346	300
Anglo	1620	1501	1123	674	584	496	406	327
API	86	70	61	53	45	46	26	36
Latino	1095	1124	924	812	746	686	613	524
Ntv Am/Alaskan	13	20	8	5	10	6	6	4
TOTAL OF ABOVE POPS	**3,658**	**3,438**	**2,711**	**2,086**	**1,841**	**1,655**	**1,397**	**1,191**

New AIDS Cases by Risk Group

Figure 1-8 shows an unequal decline in diagnosed AIDS cases for risk groups. MSM (men having sex with men) show a significant decline in number of AIDS cases diagnosed yearly from 1994 through 1997, when the rate of decline began to level off. Between 1998 and 2001 the number of newly diagnosed cases continued to decline but at a slower pace. Nonetheless, in 2001, MSM account for over 65% of the newly diagnosed cases. The slowing rate of decline in newly diagnosed AIDS cases may also reflect a higher rate of infections among MSM. This is also supported later in the co-morbidity section where the rates of syphilis and gonorrhea have been on the rise, particularly among MSM. It is further supported by the high rates of infection indicated by the Young Men's Survey where14% of the young gay Latinos and 32% of young gay African Americans have been infected. The fact that a large proportion did not know they were infected, suggests that HIV rates are disproportionately high among the young gay men of color.

Since 1994, MSM/IDU have shown the second largest decline in newly diagnosed AIDS cases followed by IDUs and heterosexuals. Unlike other large EMAs like New York, where IDUs play a significant role in new infections, in Los Angeles County the number of new cases attributable to IDUs has remained relatively low. There appears to be a small shift in new infections toward heterosexuals in the epidemic where, in 2001, the proportion of MSM/IDU among new cases fell below the proportion of heterosexuals, and they now account for about the same proportion of living AIDS cases as IDUs (7%).

Figure 1-8 AIDS Cases by Year of Diagnosis by Risk Group

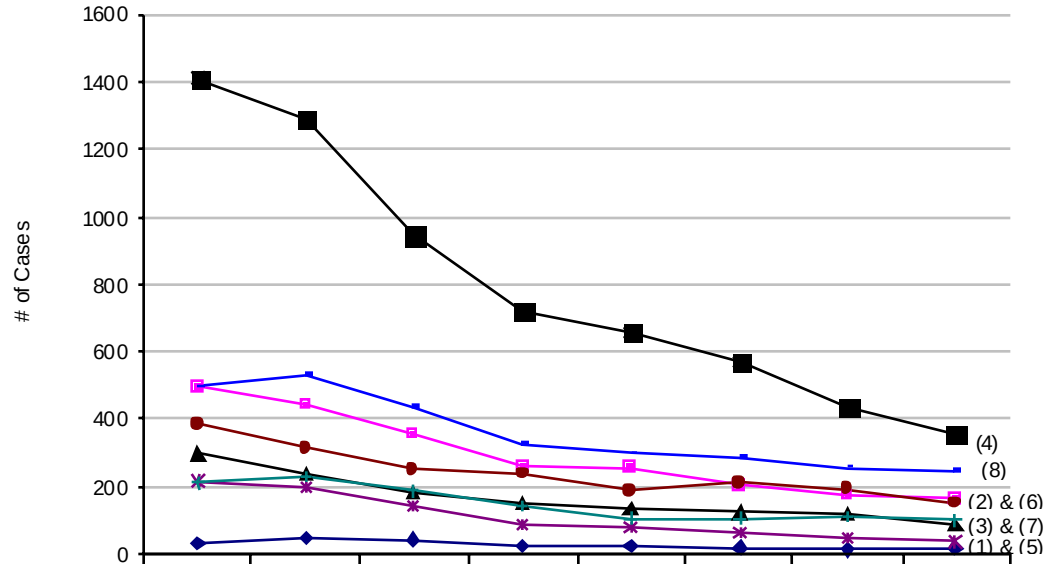


	1994	1995	1996	1997	1998	1999	2000	2001
MSM	2579	2341	1799	1193	1044	913	733	616
MSM/IDU	206	197	140	102	91	69	63	59
IDU	329	268	232	198	141	117	113	112
Het	200	256	187	182	154	135	125	95
Not Classified	275	324	319	382	402	414	355	297
TOTAL	**3,589**	**3,386**	**2,677**	**2,057**	**1,832**	**1,648**	**1,389**	**1,179**

New AIDS cases by SPA

Figure 1-9 displays the decline in AIDS cases reported yearly in the eight SPAs in the Los Angeles County. Consistently, since 1994, the Metro SPA has accounted for the largest proportion of all PLWH/A, with over one third of the cases, followed by SPA 8 the South Bay-Long Beach SPA with about 15% of the newly diagnosed cases. In the Metro SPA, 1,411 AIDS cases were diagnosed in 1994 and 351 in 2001. The West and Metro SPA had fastest decline in newly diagnosed AIDS cases.

Figure 1-9 AIDS Cases by Year of Diagnosis by SPA



	1994	1995	1996	1997	1998	1999	2000	2001
Antelope (1)	31	49	39	26	23	19	14	17
San Fernando (2)	493	439	352	260	254	205	173	165
San Gabriel (3)	293	235	177	150	132	121	114	88
Metro (4)	1411	1287	943	718	653	566	435	351
West (5)	215	199	139	85	78	65	45	35
South (6)	382	313	251	240	188	206	193	152
East (7)	209	225	186	141	105	106	109	98
South Bay (8)	492	529	432	324	295	283	255	245
TOTAL	**3,526**	**3,276**	**2,519**	**1,944**	**1,728**	**1,571**	**1,338**	**1,151**

Medication and Adherence

Another outcome of the system is adherence to medication. Despite the availability of adherence programs, PLWH/A report mixed results.

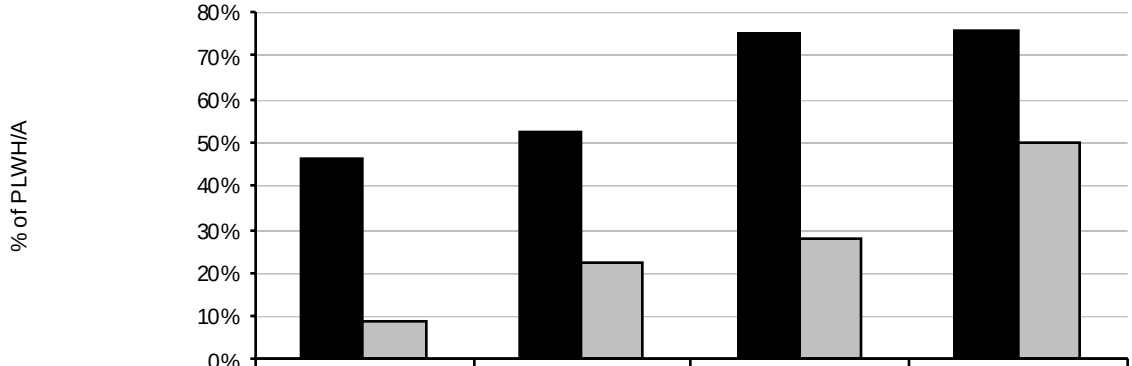
Taking Medication

The use of combination therapy and prophylactics to prevent opportunistic infections has greatly improved the length and contributed to the quality of life of PLWH/A. Continued

and improved health status outcomes will depend, in part, on the availability, access, and adherence to properly prescribed medical regimens.

Based on data from the 2002 needs assessment survey of both PLWA and PLWH, 49% of PLWH and 75% of PLWA report ever taking medicines to treat their HIV infection. This compares to 95% of the PLWA interviewed for the SHAS study, who report ever using antiretroviral medication. The much higher history of medication use reported by SHAS participants is consistent with the anticipated linear relationship of medication use with stage of disease. As shown in Figure 1-10, symptomatic PLWA (75%) are more likely to report taking medication than are asymptomatic PLWH (47%).

Figure 1-10 Medication by Stage of Infection



	HIV asymp	HIV symp	AIDS asymp	AIDS symp
% taking antiretrovirals	46.6%	52.5%	75.0%	75.6%
% taking antibiotics	8.6%	22.5%	27.5%	50.0%

Men (65%) are more likely than women (56%) to have taken HIV medications, reflecting, in part their longer length of HIV infection. It may, however, also represent lower levels of knowledge or other barriers for women. These are discussed further in the Barriers Section of this Plan. The currently homeless or in transitional housing, heterosexuals and African American MSM report lower uses of medication than other populations. More than half of the currently homeless report not having ever taken medications to treat their HIV. This may be due to a number of factors including unstable housing situation, increased co-morbidity with substance use, and or poor access to health care. These barriers are father explored in the section on these special populations.

Adherence

Thirty-three percent (33%) of the PLWH/A in the 2002 needs assessment survey report never skipping their medications, and at the other extreme, 14% have stopped taking their medicines. Sixty-eight percent (68%) of the PLWA from the SHAS interviews report never skipping their medications. The difference may reflect the much higher adherence of PLWA (measured in SHAS) in contrast to those living with HIV whom represents 45% of those living with HIV/AIDS in the 2002 Needs Assessment Survey.

Figure 1-11 shows adherence to medications across different sub-populations. Data from the 2002 needs assessment reveals that:

- Men and women tend to report about the same level (66–68%) of difficulty adhering to their medication schedule. However, women are more likely (19%) than men (11%) to have stopped taking their medications all together.
- APIs are more likely to adhere to their medications than any other ethnic population, while African Americans are the least likely to adhere. Latinos and Native Americans are more likely than the other ethnic populations to stop taking medications.
- More than 80% of the MSM/IDU and PLWH/A in Antelope Valley and South Bay SPAs have difficulty adhering to their medications.
- Notably, symptomatic PLWH/A are more likely to stop taking their medication than asymptomatic PLWH/A.

Figure 1-11 PLWH/A Who've Never Skipped Their Medications

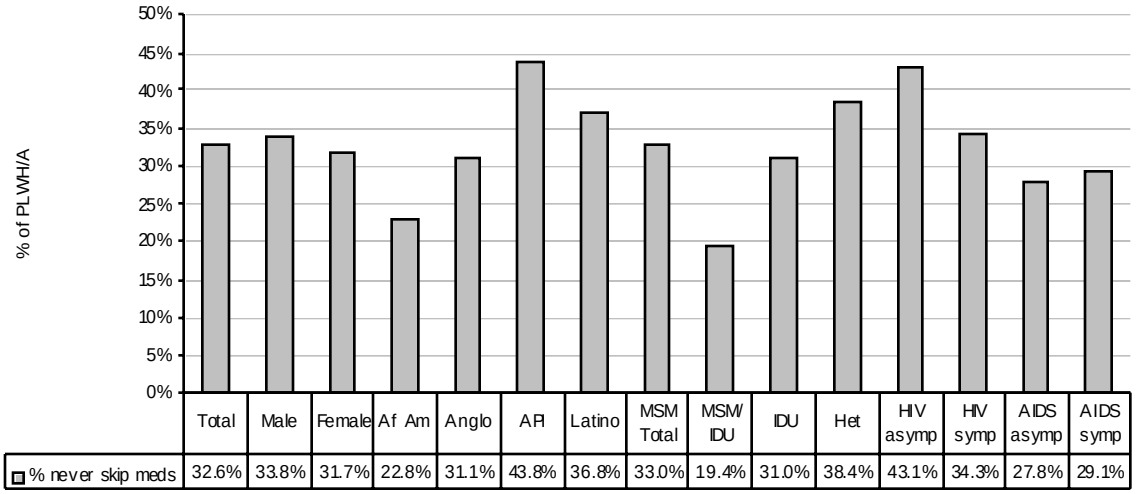


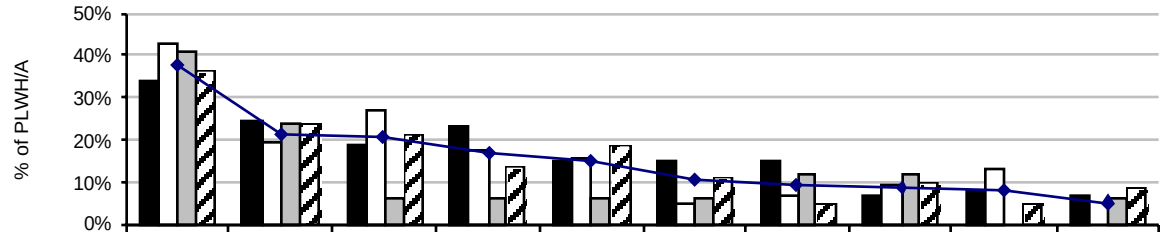
Figure 1-12 and Figure 1-13 show the top reasons for discontinuing medications for all PLWH/A.

The findings indicate that:

- Forgetting to take medications, side effects and not wanting to take the medications are the top reasons for discontinued or inconsistent use of medications.
- Among all groups, forgetting to take them (38%) is typically the major reason for skipping medication, with IDUs (50%), and PLWH/A in the South Bay (52%) and Antelope Valley (56%) SPA being the most likely to forget.
- PLWA are more likely to forget to take their medications than are PLWH.
- The next two most common reasons cited for skipping doses were side effects of medications (22%) and not wanting to take medications. Women of childbearing years (32%), and PLWH/A in the Antelope Valley (33%) and South Bay (36%) SPA report having a greater problem with side effects than other groups.

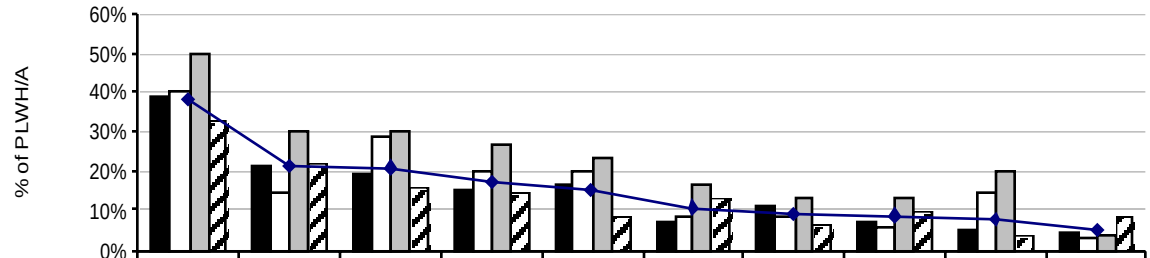
- The three least cited reasons for not taking medication include "medications did not work" (5%), "felt that did not need medications" (5%) and "affordability" (3%).
- Eight percent of the PLWH/A reported being homeless as one of their reasons for skipping medications.

Figure 1-12 Reasons for Skipping Medications by Ethnicity



	Forgot	Side effects	Didn't want to take them	Difficult schedule	Hard to coordinate w/ food	Med Confidentiality	Ran out of meds	Doctor advise	Homeless	Didn't understand directions
Af Am	33.8%	24.3%	18.9%	23.0%	14.9%	14.9%	14.9%	6.8%	8.1%	6.8%
Anglo	42.9%	19.0%	27.0%	17.5%	15.9%	4.8%	6.3%	9.5%	12.7%	0.0%
API	41.2%	23.5%	5.9%	5.9%	5.9%	5.9%	11.8%	11.8%	0.0%	5.9%
Latino	36.3%	23.8%	21.3%	13.8%	19.0%	11.3%	5.0%	10.0%	5.0%	8.8%
Total	38.2%	21.5%	20.7%	17.1%	15.1%	10.6%	9.3%	8.5%	7.7%	5.3%

Figure 1-13 Reasons for Skipping Medications by Mode of Transmission



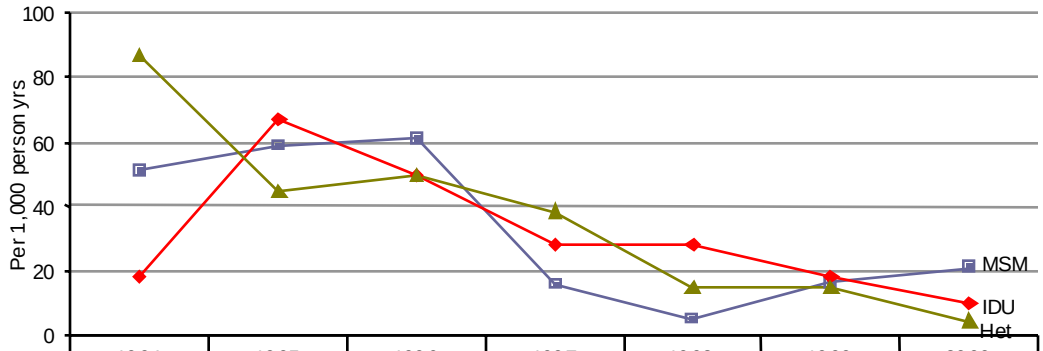
	Forgot	Side effects	Didn't want to take them	Difficult schedule	Hard to coordinate w/ food	Med Confidentiality	Ran out of meds	Doctor advise	Homeless	Didn't understand directions
MSM	38.8%	21.4%	19.4%	15.3%	16.3%	7.1%	11.2%	7.1%	5.1%	4.1%
MSM/IDU	40.0%	14.3%	28.6%	20.0%	20.0%	8.6%	8.6%	5.7%	14.3%	2.9%
IDU	50.0%	30.0%	30.0%	26.7%	23.3%	16.7%	13.3%	13.3%	20.0%	3.3%
Het	32.5%	21.7%	15.7%	14.5%	8.5%	13.3%	6.0%	9.6%	3.6%	8.4%
Total	38.2%	21.5%	20.7%	17.1%	15.1%	10.6%	9.3%	8.5%	7.7%	5.3%

Overall, nine percent of PLWH/A report they stopped taking their medications under advice from a doctor. PLWH/A in the South Bay SPA (23%) and women of childbearing years (17%) cited this reason more frequently than other groups.

Opportunistic Infections (OIs)

The incidence of OIs, particularly *Pneumocytis carinii* pneumonia (PCP), can be used as an outcome for the continuum of care. For the most part, PCP is preventable provided the PLWH/A remain on their medical regimen and, should their T-cell count fall below 300, begin a prophylactic of antibiotics. Controlling PCP in the epidemic then requires early detection, adherence, and regular monitoring. As shown in Figure 1-14, the trend for PCP is downward. However, the increased rate of PCP among MSM indicates a potential problem.

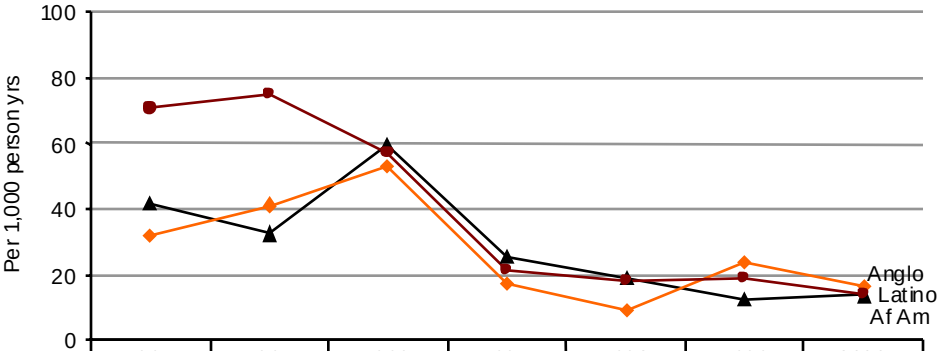
Figure 1-14 PCP by Risk Group



	1994	1995	1996	1997	1998	1999	2000
MSM	50.7	58.7	60.7	16.1	5.4	16.4	21.3
IDU	18.6	66.7	49.8	28.3	28.3	18.4	10.1
Het	86.2	44.8	49.7	38.4	15.1	15.3	5.0

When examined by race, Figure 1-15 shows that there is an increase in the incidence of PCP among Anglos, suggesting that medication may not working as effectively as in the past or that adherence may be a problem among this population. As more data becomes available for 2001 and 2002 the trend should be monitored.

Figure 1-15 PCP by Race



	1994	1995	1996	1997	1998	1999	2000
Af Am	41.9	32.3	59.3	25.4	18.8	12.5	13.3
Anglo	32.0	41.3	52.7	17.0	8.9	23.4	16.2
Latino	70.8	75.2	57.3	21.1	18.3	19.1	14.2

Quality of Life

Other outcomes measured for the system of care are current and changed physical and emotional health. While no baseline physical or emotional health measures are available for PLWH/A, survey participants rated their current physical and emotional health and then compared it to "when they first sought treatment for their HIV infection" (questions 23 through 26, Attachment 1). The assumption tested is that access to care, and in particular to new HIV drug therapies, has a positive impact on the physical and mental health of PLWH/A seeking care. Consequently, improved physical or emotional health after seeking treatment would suggest the care system is meeting one of its major objectives.

Drug therapies, however, may not have the same beneficial affect across all populations, and some PLWH/A may experience severe side effects that compromise both physical and emotional health. Additionally, there are disparities in access to care and treatment that may also impact quality of life. As a result of these factors, it is expected that some of the survey respondents will report decreasing physical and emotional health regardless of the quality of the treatment.

Figure 1-16 and Figure 1-17 report the current and perceived change in physical health and emotional health. It is divided into three independent groups: 1) PLWH who are asymptomatic, 2) PLWH who are symptomatic, and 3) those who report being diagnosed with AIDS. Of those living with AIDS, 70% said they were symptomatic and 30% said they were asymptomatic.

- The majority of asymptomatic PLWH are doing "good" to "excellent" and many feel they are much better than when first diagnosed. Fifty-seven percent (57%) say that their physical health is better now as compared to when they first sought treatment and another third say their health is the same.
- In contrast, about 55% of symptomatic PLWH report that their physical health is currently fair to poor. A third of these PLWH say they are doing worse than when first diagnosed--which may be connected to their recent symptoms and possibly the start of HIV medications that can eventually bring side effects.
- While PLWA (13%) are more likely than asymptomatic PLWH (2%) or symptomatic PLWH (10%) to report poor health, over 70% say they have fair to good health. This is comparable to 77% of the PLWA who report the same level of health in the SHAS interviews. Overall, PLWA report the greatest improvement in health compared to those at other stages of infection since they first sought treatment for their HIV infection (61%). However, in comparison to symptomatic PLWH, symptomatic PLWA are currently not doing as well with 19% reporting poor health compared to 10% of the symptomatic PLWH.
- Overall, the care system appears to be addressing the health needs of PLWH/A and assisting them in maintaining and in many instances improving their health status. According to the LA County Health Survey, over 20% of Los Angeles County residents report a poor health status. This compares to less than 10% among the total

sample of PLWH/A. Whether it's due to increased medical monitoring, greater access to social services or heightened awareness about individual health practices, the majority (60%) of PLWH/A report doing better today compared to when they first sought treatment.

The emotional health of PLWH/A is better than their physical health.

- The seven percent (7%) of asymptomatic PLWH reporting poor emotional health may be connected to concerns about their recent diagnosis. But a large majority (75%) report better emotional health than their initial diagnosis. Only 2% of the asymptomatic PLWH are doing worse than when first sought treatment.
- The majority of symptomatic PLWH are doing "good" to "excellent." Although a third are feeling physically worse, emotionally they are doing better than when first starting treatment.
- PLWA are doing well emotionally. They are feeling better than when first seeking treatment (61%). This may have to do with success of medication therapy, some may feel better because they are dealing with drug addictions as noted in the consumer forums, and others may have consistent medical and social support for the first time in their lives.
- African American MSM (16%) report poorer current emotional health than other risk groups. Also, those with severe mental health issues (15%) and substance users (non-IDU) (14%) report poorer current emotional health.
- Women of childbearing years (WCB) (71%), the undocumented (81%), and those residents of the South SPA (68%) report the greatest improvement in their emotional health since they first sought treatment.

Overall, based on improvement in both physical and emotional health, the care system is making an impact. As a possible indication of the success of aggressive medical intervention, PLWA are able to manage their infection and report the greatest improvements physically amongst the different stages of infection. Also, asymptomatic PLWH, whose physical health has remained relatively constant, have nonetheless benefited from improved emotional health and are the population with the greatest improvements emotionally.

Figure 1-16 Quality of Life – Physical Health

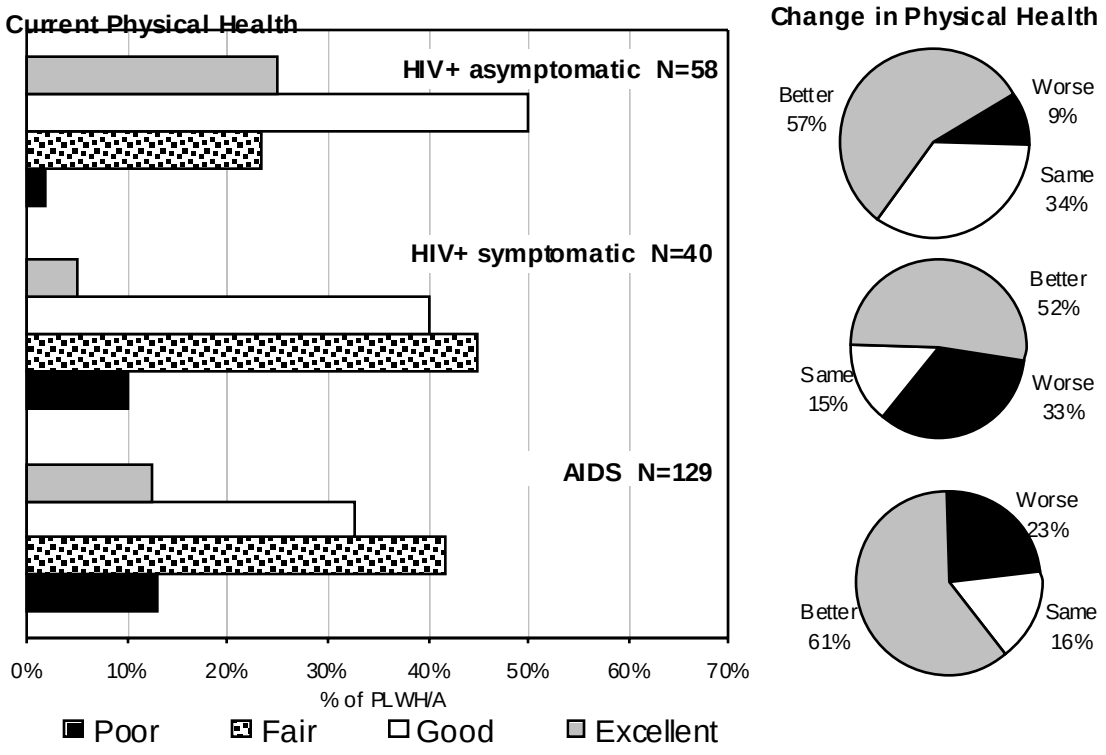
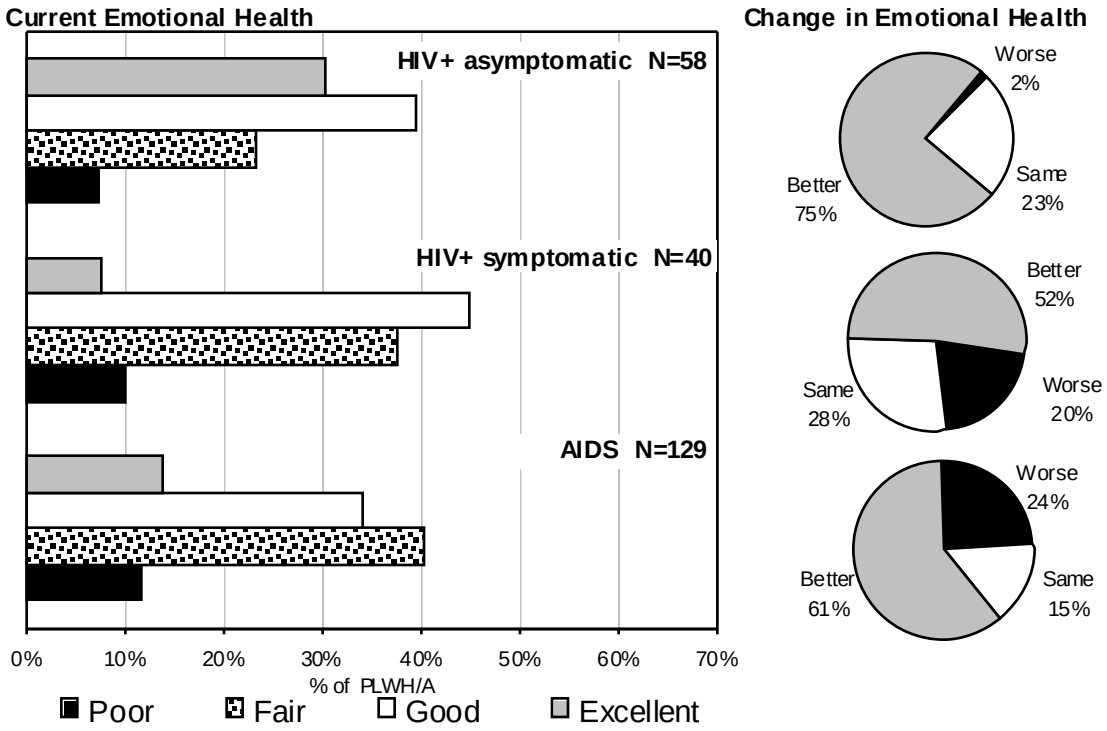


Figure 1-17 Quality of Life – Emotional Health



PROFILE OF THE LOS ANGELES EMA AND THE EPIDEMIOLOGY OF PLWH/A

Los Angeles County and the Los Angeles County EMA include the same geographic boundaries. The 2000 census reports that Los Angeles County had 9,519,338 residents, making it the most populous county in the nation. With 4,000 square miles of land, it has the second largest landmass of all the counties in the U.S. In 2000, the AIDS rate of 17.5 per 100,000 was well above the national rate of 14.7 per 100,000.

When planning for HIV and AIDS services, knowing the number of persons living with HIV and AIDS, and the number currently accessing services, provides a theoretical referent for the number of PLWH/A who could seek services in the continuum of care and the number who have sought services in the past.

Table 1-2 shows that the system currently has about 43,000 PLWH/A who know their status and thus are in need of some care services. Notably, the number living with HIV is an estimate as HIV reporting only began in July 2002 in California. The formula for the calculations is explained in Attachment 4.

Table 1-2 ESTIMATE OF PLWH/A

Living with AIDS in the Los Angeles EMA in 2001	16,547[1]
Estimated Living with HIV (not AIDS) in 2001 in the Los Angeles EMA through 2001	26,458
Living with HIV/AIDS in Los Angeles EMA in 2001 who know they are infected	42,994
Estimated Total PLWH/A	52,512
Number of PLWH/A who receive care from CARE Act-funded providers (unduplicated)	19,149[2]

1. From HARS
2. From OAPP service utilization data collection system including 677 collateral HIV- family members

In theory, the need for CARE Act-funded services is measured by first understanding the current utilization of services outside of the CARE Act-funded service system, and then calculating the "residual" as the number needing CARE Act-funded services.

Based on the estimates presented in Table 1-2, 19,149 PLWH/A and collaterals (family members, children, etc.) are receiving at least one CARE Act-funded service. Consequently, 23,845 PLWH/A, about 55% of those who know their status are not seeking care through a CARE Act-funded provider.

Assuming that the client tracking system is recording most of those receiving CARE Act-funded services, one challenge is determining how many of the 55% of PLWH/A not accounted for in the client tracking system need, but are not receiving, CARE Act-funded services and how many receive these services from other sources. In addition, in allocating funding, the legislative responsibility of the Commission is to assure that emergency services are used as funds of last resort. That is, to assure that other available funding is used for services before using the Ryan White CARE Act funds. Consequently, the task is to estimate how many of those accessing CARE Act-funded services or in need of services could be accessing other reimbursement streams such as MediCal, Medicare, federal insurance programs such as CHIP for low-income mothers and children, or private insurance.

Unfortunately, there are few accessible information sources that provide the information on who is seeking care outside of the Ryan Funded services. The Commission gas launched a financial needs assessment to better uncover, collect and interpret other sources of funding data. This plan presents a number of ways to calculate this and for making informed decisions about priorities and allocations. The information reported includes:

- Stated need for each service in the continuum of care based on survey data;
- Utilization based on self-reported use and client tracking systems;
- The number of PLWH/A eligible for each service;
- Accepted protocols for each service; and
- Eligibility based on income with the usual 300% of federal poverty level (FPL) cut-off for receiving CARE Act-funded services, stage of infection for accessing acute care services, and insurance status.

As expressed in the values of the Commission, another criteria for estimating need is to assure that services are available, accessible, culturally appropriate, and affordable. That means understanding the epidemic by various racial and ethnic populations, risk groups, and special populations. In addition, the Commission has begun the process of more fully understanding the geographic dynamics of the epidemic to further apportion services equitably throughout Los Angeles County. In this way disparities among key subgroups and different areas can be closed.

Persons Living With AIDS

In planning HIV/AIDS services, the HIV/AIDS continuum of care will need to provide services to an increasing number of PLWH/A. While the rate of transmission is dropping, it is more than offset by the declining mortality rate. The figures on PLWA alone show a dramatic increase since 1994. The number of PLWA in the Los Angeles County has grown from 13,653 in 1994, to 16,547 in 2001. As HIV transmission continues and HIV progression to AIDS continues to decline, the number of PLWH is likely to have shown an even more dramatic increase.

The Risk Group Profile of PLWA

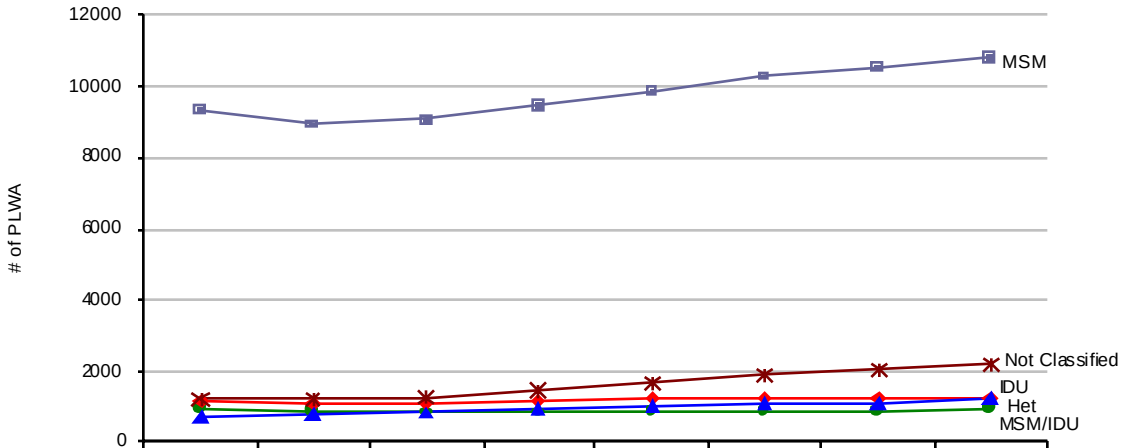
The AIDS epidemic in Los Angeles County is MSM, and has stayed at about the same proportion over time. In Figure 1-18, the percentage of MSM living with AIDS has decreased from 68% in 1994 to 65% in 2001, but unclassified PLWA has increased, it is assumed most are likely to be MSM. Generally, MSM represent about two-thirds of PLWA. With over 11,000 MSM (including MSM/IDU) living with AIDS in 2001, MSM will continue to comprise the vast majority of PLWA for the foreseeable future. Of all MSM living with AIDS in 2001, approximately 45% are Anglo, 35% are Latino, and 18% are African American. MSM, like others in the epidemic, are increasingly represented by communities of color.

The proportion of heterosexual IDUs has remained constant, representing about 8% of the PLWA. In 2001, the 1,238 PLWA who are IDUs are slightly more likely to be African American, with about 37% African American than Latino (31%) or Anglo (31%). Given the

much lower percentage of African Americans in the population, they contribute a disproportionate number of IDUs living with AIDS to the overall epidemic.

The proportion of heterosexuals (non-IDU) living with AIDS has increased from 5% in 1994 to 7%, or about 1,183 heterosexuals living with AIDS at the end of 2001. Since 1994, this number represents a 60% increase from the 743 cases reported in 1994, and is one of the largest increases in PLWA of any risk group over the past three years. Almost half (46%) of the heterosexual PLWA are Latino, 34% are African American, and 18% are Anglo. Almost 70% of the heterosexuals are women.

Figure 1-18 Living with AIDS by Risk Group

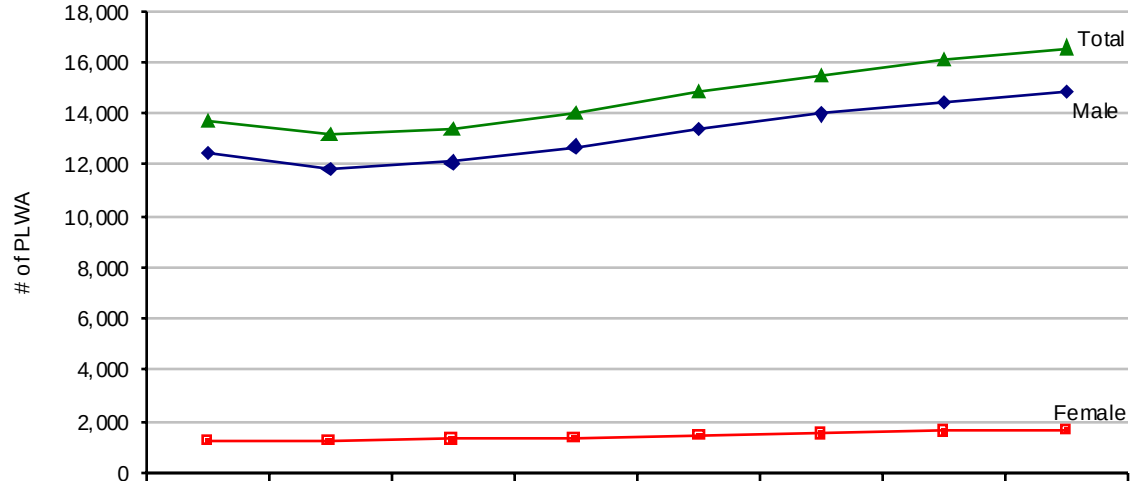


	1994	1995	1996	1997	1998	1999	2000	2001
MSM	9334	8904	9048	9445	9867	10243	10569	10801
MSM/IDU	917	845	831	828	863	881	883	895
IDU	1178	1121	1124	1150	1186	1198	1214	1238
Het	743	782	830	922	993	1062	1131	1183
Not Classified	1202	1213	1276	1454	1629	1866	2032	2180
TOTAL	13,374	12,865	13,109	13,799	14,538	15,250	15,829	16,297

The Gender Profile of PLWA

As shown in Figure 1-19, males continue to represent about 90% of PLWA. However, females living with AIDS have increased by more than 40% since 1994, compared to about a 20% increase among men. In 2001, women account for the vast majority (70%) of heterosexuals living with AIDS and about 31% of the IDUs. Since 1994, the proportion of female PLWA has increased slightly from about 9% to 10% in 2001.

Figure 1-19 PLWA by Gender



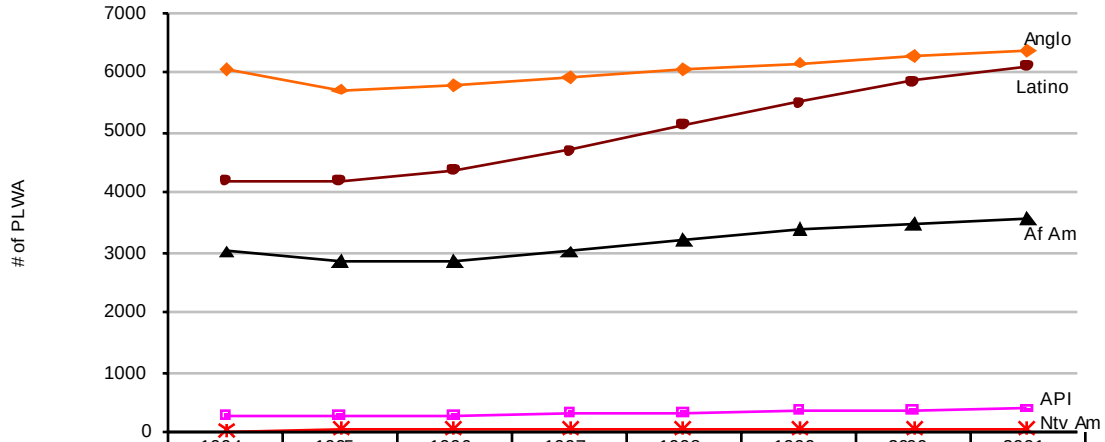
	1994	1995	1996	1997	1998	1999	2000	2001
Total	13,653	13,123	13,356	14,049	14,787	15,494	16,074	16,547
Male	12,469	11,900	12,079	12,671	13,350	13,976	14,460	14,854
Female	1,184	1,223	1,277	1,378	1,437	1,518	1,614	1,693
TOTAL	**27,306**	**26,246**	**26,712**	**28,098**	**29,574**	**30,988**	**32,148**	**33,094**

The Ethnic Profile of PLWA

The racial/ethnic makeup of Los Angeles County is 46% Latino, 33% Anglo, 12% Asian/Pacific Islanders, 8.5% African Americans, and 1% Native Americans. Figure 1-21 shows that the HIV/AIDS epidemic has affected ethnic groups quite differently, and shows the epidemic is continuing to shift from the Anglo communities to communities of color.

Figure 1-20 shows the increase in PLWA by ethnicity. While the proportion of Anglo PLWA has declined since 1994, in 2001, Anglos continue to represent the largest population (38%) of PLWA, followed closely by Latinos (37%). Notably, there is a considerable increase in Latino living with AIDS since 1994. While Anglos have increased from 6,068 living cases in 1994 to 6,352 cases in 2001, a 46% percent increase among Latinos living with AIDS from 1994 to 2001, means that about the same number of Latino PLWA (6,126) and Anglos (6,352) are in need of services in 2001. African Americans have increased from 3,008 to 3,557, representing a 19% increase. Together, Asian Pacific Islanders and Native American/Alaskans (noted in graphic as Other) comprise less than 3% of PLWA in 2001.

Figure 1-20 Living with AIDS by Ethnicity



	1994	1995	1996	1997	1998	1999	2000	2001
Af Am	3008	2848	2843	3013	3200	3372	3481	3577
Anglo	6068	5732	5793	5934	6055	6166	6272	6352
API	275	273	269	294	325	351	361	381
Latino	4202	4178	4358	4715	5108	5502	5853	6126
Ntv Am/Alaskan	41	51	53	55	60	63	66	68
TOTAL	**13,594**	**13,082**	**13,316**	**14,011**	**14,748**	**15,454**	**16,033**	**16,504**

Subpopulations with Small Numbers of PLWA

While there are few PLWA who are Asian/Pacific Islanders, Native American or under 24 years of age, they have special needs, which include the provision of culturally appropriate services. For example, providers must take into consideration legal or emotional issues of young PLWA, particularly adolescent PLWA, and those minors with gay, bisexual and/or transgender sexual orientation. In 2001, there were 381 Asian/Pacific Islanders, 68 Native Americans and 183 young adults living with AIDS.

While the proportion of new cases among young adults has remained at about 3% since 1994, the actual number of persons ages 13-24 living with AIDS has decreased dramatically since that time, going from 379 persons to 183 persons. Young adults living with AIDS display a wide range of risk factors. They were most likely to be MSM (34%); however, about 16% report exposure through transfusion or blood products and an additional 10% report maternal exposure. The young adults living with AIDS who report maternal exposure suggest the success of the medical regimen, with pediatric cases surviving into adolescence with AIDS. A larger percentage (24%) than in other age groups remained unclassified.

To obtain a more complete picture of the epidemic and to determine the extent of the need for early treatment, the next section discusses and compares estimates of HIV along with reported prevalence of AIDS.

PLWH/A: Disproportionate Impact

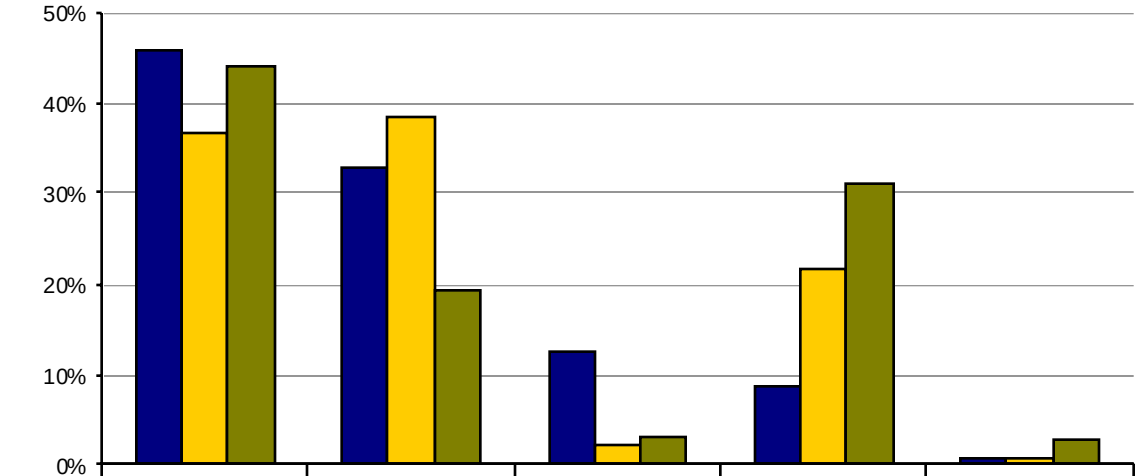
The Los Angeles County HIV Epidemiology Program estimated AIDS Incidence in calendar year 2001, and the number of PLWA and PLWH as of December 31, 2001 (see Figure 1-21). From these estimates, trends in HIV can be discussed.

Ethnic Racial Distribution of HIV and AIDS

Figure 1-21 shows that the HIV/AIDS epidemic has affected ethnic groups quite differently, and demonstrates that the epidemic is shifting from the Anglo communities to communities of color. While the largest number of PLWA are Anglo (40%) followed by Latinos (36%) and African Americans (21.5%), those who are HIV+ and have not progressed to AIDS are more likely to be Latino (43%) and African American (31%), than Anglo (20%).

The first set of bars in the Figure 1-21 indicates that Latinos represent 46% of Los Angeles County residents. While they represent the highest percentage of PLWH and PLWA, Latinos are not disproportionately affected. Anglos, the second largest population group in Los Angeles County, are disproportionately represented in AIDS cases, but have far fewer HIV cases. On the other hand, African Americans, with about 9% of the population, account for 22% of the PLWA and 31% of those living with HIV, indicating the disproportionate impact of the epidemic on African American communities and the growing epidemic in African American communities. Notably, APIs, the third largest ethnic/racial community with 12% of the Los Angeles County population, represent less than 3% of PLWH/A. Native Americans and other ethnic groups have less than 1% of the populations. However, they may be disproportionately affected by the epidemic and ways to effectively reach Native Americans are being explored by the Commission.

Figure 1-21 Impact of HIV/AIDS Epidemic on Racial/Ethnic Communities in Los Angeles County



	Latino	Anglo	API	Af Am	Ntv Am / Other
Pop	45.7%	32.7%	12.3%	8.5%	0.7%
PLWA	36.8%	38.6%	2.3%	21.6%	0.7%
PLWH	44.0%	19.3%	3.0%	31.1%	2.6%

Regional Variation

The rate of infection in each SPA varies widely. As shown in Table 1-3, AIDS rates ranges from a high of 32 per 100,000 in the Metro SPA to 5 per 100,000 in Antelope Valley. The table suggests is that the Metro SPA will continue to be the largest epicenter of the epidemic in Los Angeles County. The South Bay-Long Beach SPA will also continue to be a second, slower-growing epicenter. The South SPA, with a large proportion of African Americans will play a larger role in the epidemic.

While rates of infection are useful in comparing areas and projecting increase in service need in planning services, numbers of person infected provide a more concrete indication of number of persons who must have services. Consequently, Table 1-3 also shows the numbers of persons in Los Angeles County by SPA and the number living with AIDS and HIV. It shows that the Metro SPA had 6,189 PLWA and an estimated 9,452 PLWH at the end of 2001 who should receive services. At less than half the number, the South Bay-Long Beach SPA has over 2,650 PLWA and 4,122 PLWH, and San Fernando Valley has about 2,130 PLWA and 3,130 PLWH in need of services.

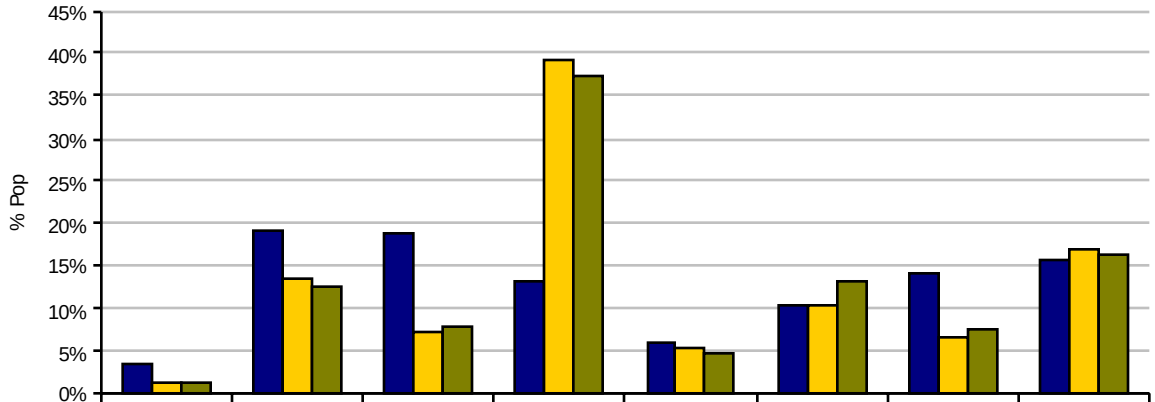
Table 1-3 Population and PLWA by SPA

*SPA	Rate of AIDS Per 100,000	POPULATION	PLWA	PLWH (estimate)
1 Antelope Valley	4	328,537	172	258
2 San Fernando Valley	9	1,864,747	2,136	3,136
3 San Gabriel Valley	6	1,835,780	1,115	1,937
4 Metro	33	1,303,526	6,189	9,452
5 West	8	579,490	861	1,160
6 South	19	1,016,052	1,583	3,302
7 East	8	1,384,898	1,032	1,828
8 South Bay-Long Beach	17	1,533,683	2,652	4,122
TOTAL		**9,846,713**	**15,740***	**25,195**

* Does not include 807 PLWA with unreported SPA residence.

Figure 1-22 displays the regional profile, showing that PLWH/A are much more likely to reside in the Metro and South Bay-Long Beach SPA than other SPAs. San Fernando Valley, with about 19% of the population, has about 14% of PLWA, and San Gabriel Valley, also with about 19% of the population has slightly over 7% of PLWA. On the other hand, the Metro SPA, with 13% of the population has nearly 40% of PLWA, and South Bay-Long Beach has about 16% of the population and 16% of PLWH/A. In most SPAs (SPA 3, 4 and 8) the percentage of PLWA is about the same as percentage of PLWH. Notably the two SPAs with the most heavily represented communities of color have proportionately more HIV cases.

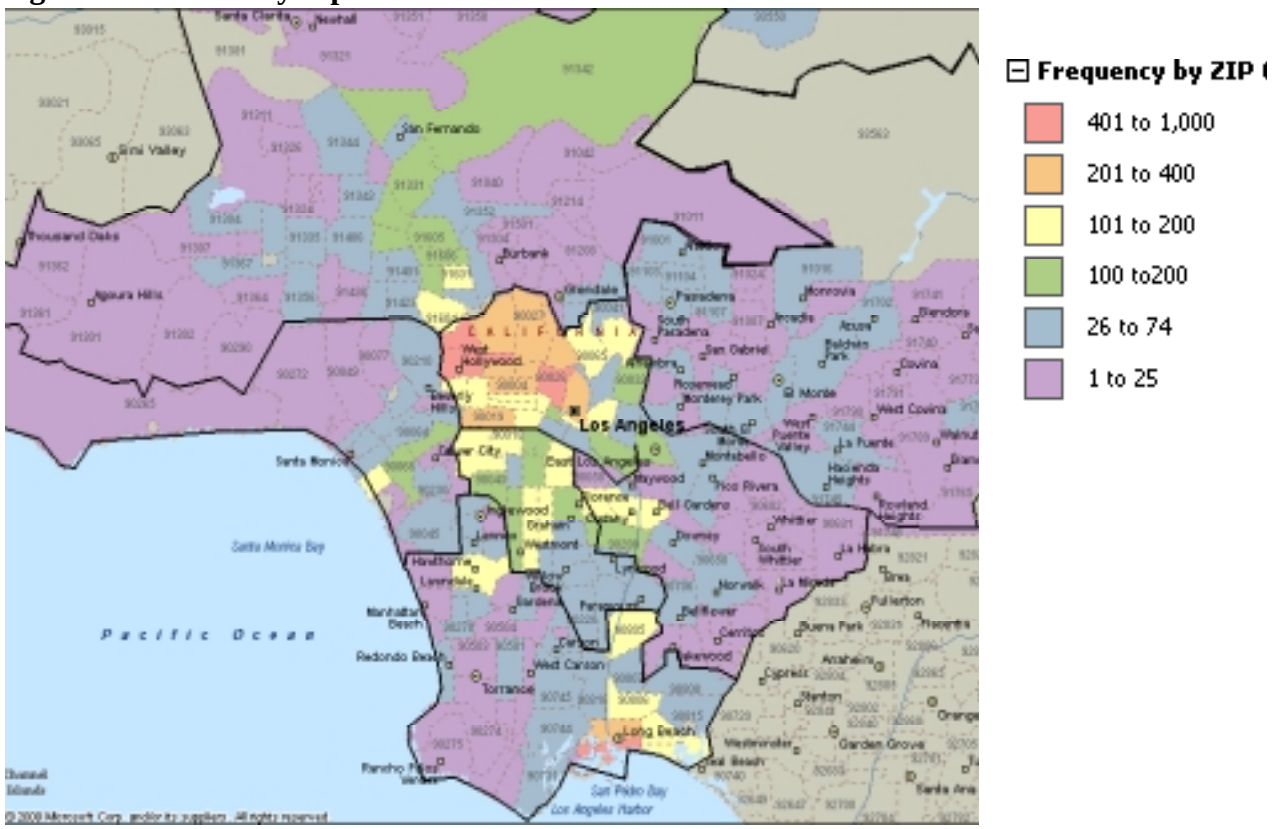
Figure 1-22 Population and PLWA by SPA

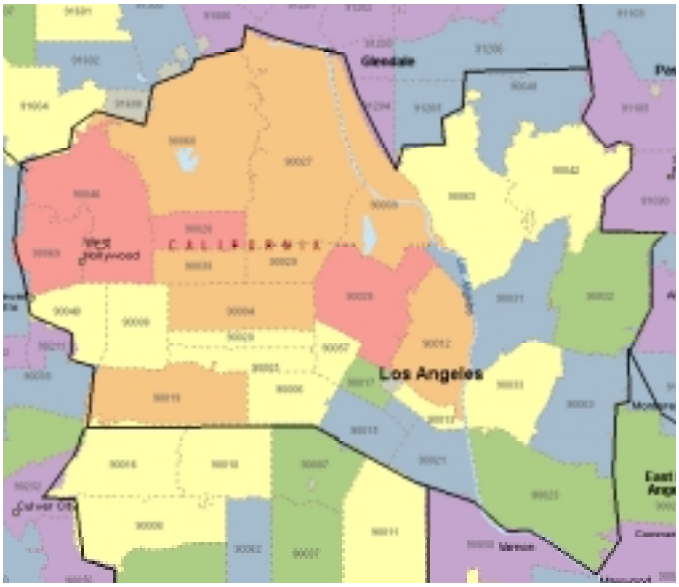


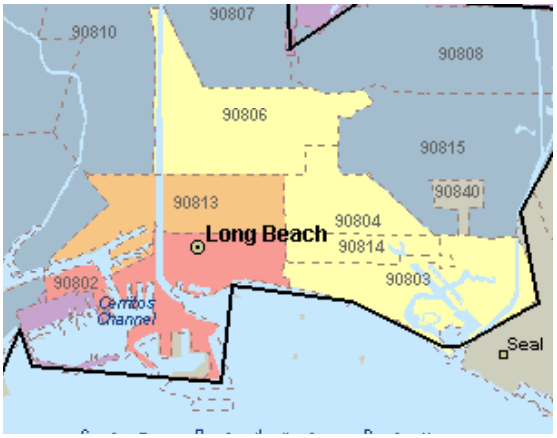
	SPA 1 Antelope Valley	SPA 2 San Fernando Valley	SPA 3 San Gabriel Valley	SPA 4 Metro	SPA 5 West	SPA 6 South	SPA 7 East	SPA 8 South Bay Harbor
POP	3.3%	18.9%	18.6%	13.2%	5.9%	10.3%	14.1%	15.6%
AIDS	1.1%	13.6%	7.1%	39.3%	5.5%	10.1%	6.6%	16.8%
PLWH	1.0%	12.4%	7.7%	37.5%	4.6%	13.1%	7.3%	16.4%

The map in Figure 1-23 confirms the unequal distribution of AIDS in Los Angeles County. Notably the zip codes with highest incidence are located in the Metro SPA, particularly West Hollywood, Hollywood (zip codes 90046, 90069, and 90028), East Hollywood/Echo Park (zip code 90026) and South Bay-Long Beach SPA, particularly in the Long Beach area (zip codes 90802, 90801 and 90832). The map shows the two epicenters in Los Angeles County and shows its spread outward. The West Hollywood epicenter appears to spread northeast, with the more current spread northward into the San Gabriel Valley, along the 170 and 5 freeways. In South SPA, it appears to follow the 110. The Long Beach epicenter seems to spread north, but also appears to be spreading more slowly.

Figure 1-23 AIDS by Zip







The differences in the impact of HIV and AIDS by SPA is further displayed in Figure 1-24 where the percentage of population (first bar in series), percentage of PLWA (second bar in series), and percentage of PLWH (third bar in series) are compared for each SPA. The "diamonds" in the graph indicate the percentage of the population, percentage of PLWA, and percentage of PLWH for Los Angeles County. Thus, if the diamonds are above the bars it indicates that the impact in the SPA is relatively less than the overall impact in Los Angeles County. On the other hand, if the diamonds fall within the bars, the impact in the SPA is relatively greater than the impact in Los Angeles County. Last, in looking at the figures, the pattern of the diamonds and bars indicate if the pattern in Los Angeles County and the pattern of PLWH/A are similar or different.

Highlights include:

SPA 1, Antelope Valley, has 3% of the total population and is the least populated SPA. It is majority Anglo (63%), followed by Latino (24%) and African American (6%). Anglos represent nearly 50% of the AIDS cases, but African Americans are very disproportionately represented among PLWH/A and are more likely to have HIV than other ethnic communities. With the declining epidemic among Anglos and the low population, SPA 1 will continue to have few cases of HIV/AIDS with the fastest increase being among African Americans.

SPA 2, San Fernando Valley, has just under a fifth of the population of Los Angeles County, and its racial/ethnic mix is more likely to represent Anglos (46%) and Latinos (35%) than African Americans (11.5%) or APIs (3%). About 50% of HIV and AIDS cases are among Anglos, followed by Latinos (about a third of the PLWH/A). African Americans account for about 11.5% of the PLWA and 15% of PLWH. SPA 2, with a disproportionate number of Anglos living with HIV/AIDS, is notable for its high HIV rate among Anglos, and, along with SPA 4, accounts for the greatest number of Anglos in the epidemic.

SPA 3, San Gabriel Valley, like SPA 2, has just under a fifth of the population of Los Angeles County, but has a significantly different profile than San Fernando Valley. It has more APIs (19%) than any other SPA, and HIV and AIDS rates are low. The highest number of HIV and AIDS cases are among Latinos. Anglos are the second largest population group and have the next highest percentage of HIV and AIDS. However, African Americans, with just 5% of the population, account for about a quarter of the HIV cases and over a fifth of the AIDS cases in San Gabriel Valley. Given current rates of infection, African Americans could soon overtake Anglos as the second highest number of PLWH/A in the SPA.

SPA 4, Metro, has 13% of the overall population and, compared to Los Angeles County, has more Latinos and APIs. It is one of the epicenters in Los Angeles County, with about 39% of the AIDS cases and an estimated 38% of the HIV cases in Los Angeles County. The epidemic in the Metro SPA is fueled by Anglos, who have disproportionate number of HIV and AIDS cases and Latinos, although the percent infected is relatively low compared to their overall representation in SPA 4. Like other SPAs, the relatively small African American population is disproportionately infected, and APIs account for a small number of the PLWH/A. MSM

represent over 70% of PLWH/A and are, by far, the largest risk group represented in the Metro SPA.

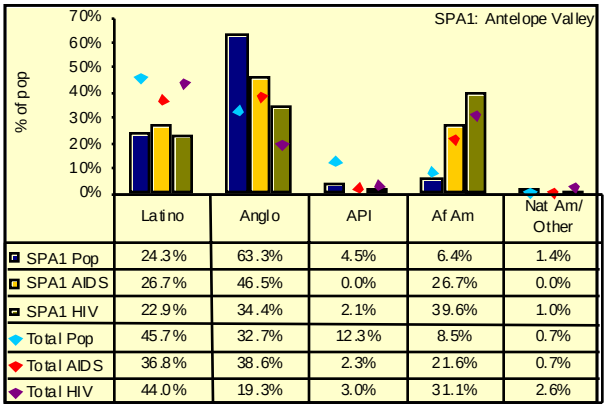
SPA 5, West, has about 6% of the population of Los Angeles County. Anglos represent about 50% of the population, and they are disproportionately represented among PLWH/A. The large decrease in HIV among Anglos shown for Los Angeles County has not been evidence in the West SPA. Latinos, with 37% of the population, account for a slightly smaller percentage of PLWH/A. African Americans, while representing only 3% of the population in the West SPA, have almost 12% of the PLWA and 15% of PLWH. Like the Metro SPA, over 70% of PLWA are MSM. However, there are proportionately fewer MSM (62%) and more heterosexuals (14%) living with HIV.

SPA 6, South, has 10% of the overall population and the epidemic is driven in large part by the African American population. While African Americans represent 35% of the population, they represent about 60% of PLWH/A. About 60% of the population in the South SPA is Latino, yet, they represent only a third of PLWH/A. There are few Anglos living in the South SPA, and while they are disproportionately infected, as they represent close to 6% of PLWH/A. MSM represent the major risk group for PLWA, but heterosexuals are the largest number of PLWH. Given the rate of infection, the South SPA is likely to have the fastest growth of HIV in Los Angeles County.

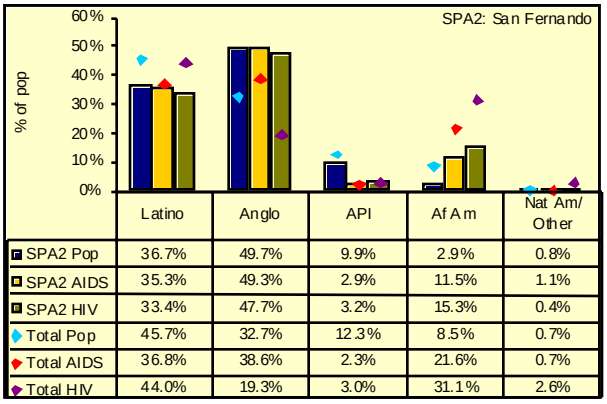
SPA 7, East, has 14% of the population in Los Angeles County. Latinos represent 65% of the East SPA residents, followed by Anglos (24%) and APIs (8%). The East SPA is less than 2% African American residents. SPA 7 has about 6.5% of PLWA, and Latinos account for over 70% of the PLWH/A. The Latino community will continue to populate the epidemic in this area. Like other SPAs, the African American communities are disproportionately infected, but their small numbers in the East SPA suggest a growing but small impact on the overall number of cases. While the majority of PLWH/A are MSM in the East SPA, transmission by IDU and among heterosexuals--particularly among PLWH--relatively high.

SPA 8, South Bay-Long Beach, has 16% of the population of Los Angeles County. Along with the Metro SPA, it is an epicenter in Los Angeles County, as its demographics suggest a growing epidemic of PLWA and PLWH. South Bay has a diverse population, with Anglos representing 37% of the population, Latinos a third, APIs 16% and African Americans 13%. Infection rates are particularly high among African American with about the same number of AIDS cases as Latinos and more PLWH. About two thirds of PLWA are MSM and PLWH are over 50% MSM. HIV and AIDS attributable to IDU is relatively high, at about 10%. Heterosexual transmission is particularly high (18%) among PLWH. At the current pace, it can be expected that African Americans will become the most infected population in the next several years. Anglos will continue to be the majority of PLWA.

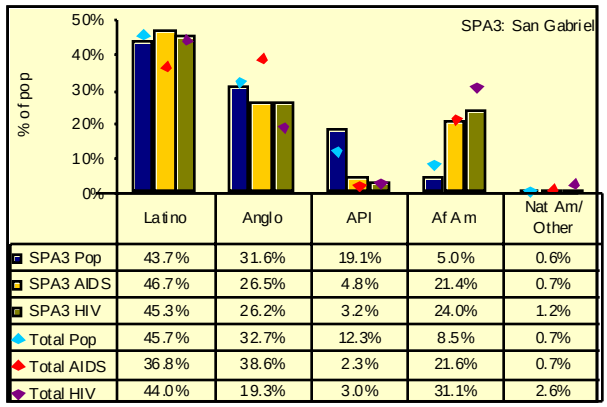
Figure 1-24 Population & PLWH/A by SPA



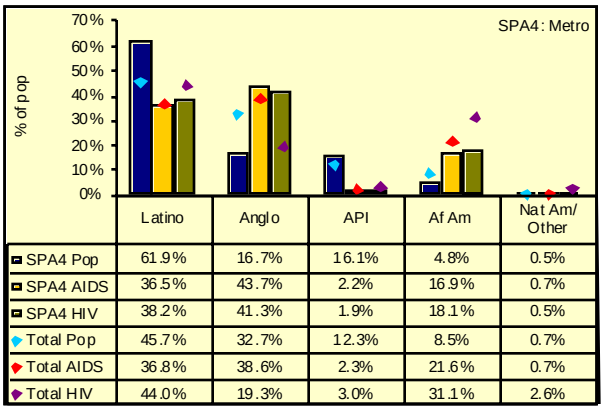
	Latino	Anglo	API	Af Am	Nat Am/ Other
SPA1 Pop	24.3%	63.3%	4.5%	6.4%	1.4%
SPA1 AIDS	26.7%	46.5%	0.0%	26.7%	0.0%
SPA1 HIV	22.9%	34.4%	2.1%	39.6%	1.0%
Total Pop	45.7%	32.7%	12.3%	8.5%	0.7%
Total AIDS	36.8%	38.6%	2.3%	21.6%	0.7%
Total HIV	44.0%	19.3%	3.0%	31.1%	2.6%



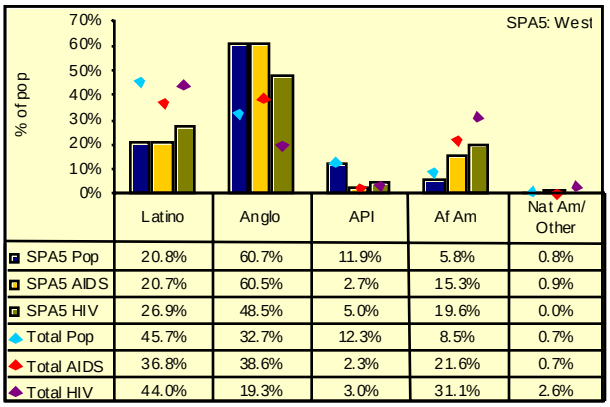
	Latino	Anglo	API	Af Am	Nat Am/ Other
SPA2 Pop	36.7%	49.7%	9.9%	2.9%	0.8%
SPA2 AIDS	35.3%	49.3%	2.9%	11.5%	1.1%
SPA2 HIV	33.4%	47.7%	3.2%	15.3%	0.4%
Total Pop	45.7%	32.7%	12.3%	8.5%	0.7%
Total AIDS	36.8%	38.6%	2.3%	21.6%	0.7%
Total HIV	44.0%	19.3%	3.0%	31.1%	2.6%



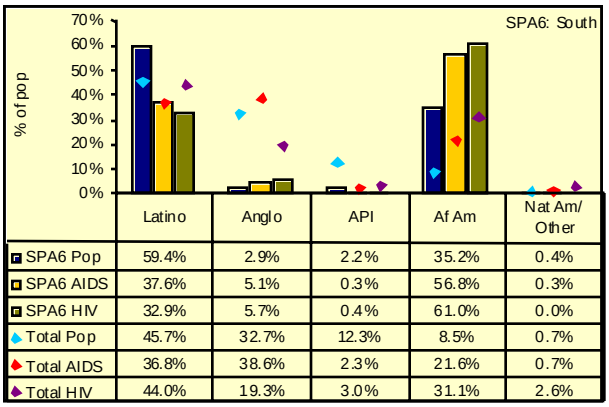
	Latino	Anglo	API	Af Am	Nat Am/ Other
SPA3 Pop	43.7%	31.6%	19.1%	5.0%	0.6%
SPA3 AIDS	46.7%	26.5%	4.8%	21.4%	0.7%
SPA3 HIV	45.3%	26.2%	3.2%	24.0%	1.2%
Total Pop	45.7%	32.7%	12.3%	8.5%	0.7%
Total AIDS	36.8%	38.6%	2.3%	21.6%	0.7%
Total HIV	44.0%	19.3%	3.0%	31.1%	2.6%



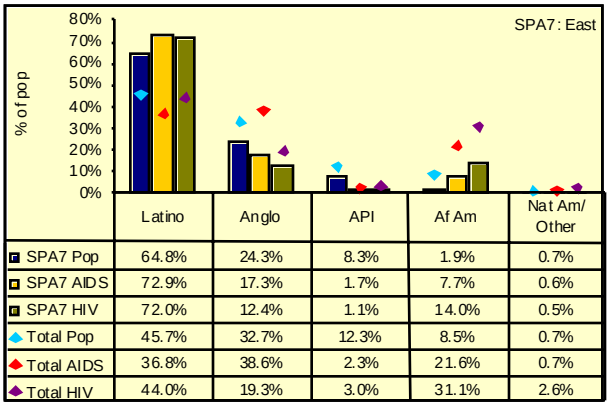
	Latino	Anglo	API	Af Am	Nat Am/ Other
SPA4 Pop	61.9%	16.7%	16.1%	4.8%	0.5%
SPA4 AIDS	36.5%	43.7%	2.2%	16.9%	0.7%
SPA4 HIV	38.2%	41.3%	1.9%	18.1%	0.5%
Total Pop	45.7%	32.7%	12.3%	8.5%	0.7%
Total AIDS	36.8%	38.6%	2.3%	21.6%	0.7%
Total HIV	44.0%	19.3%	3.0%	31.1%	2.6%



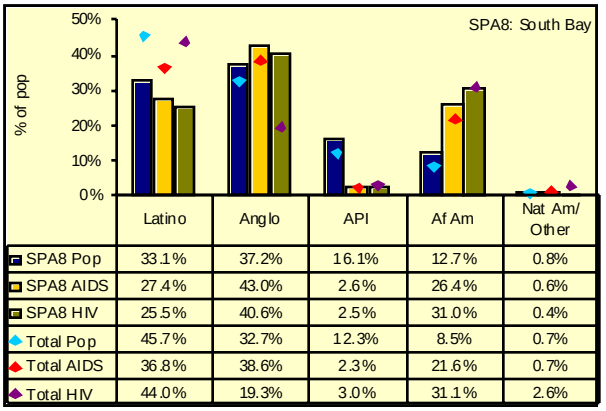
	Latino	Anglo	API	Af Am	Nat Am/ Other
SPA5 Pop	20.8%	60.7%	11.9%	5.8%	0.8%
SPA5 AIDS	20.7%	60.5%	2.7%	15.3%	0.9%
SPA5 HIV	26.9%	48.5%	5.0%	19.6%	0.0%
Total Pop	45.7%	32.7%	12.3%	8.5%	0.7%
Total AIDS	36.8%	38.6%	2.3%	21.6%	0.7%
Total HIV	44.0%	19.3%	3.0%	31.1%	2.6%



	Latino	Anglo	API	Af Am	Nat Am/ Other
SPA6 Pop	59.4%	2.9%	2.2%	35.2%	0.4%
SPA6 AIDS	37.6%	5.1%	0.3%	56.8%	0.3%
SPA6 HIV	32.9%	5.7%	0.4%	61.0%	0.0%
Total Pop	45.7%	32.7%	12.3%	8.5%	0.7%
Total AIDS	36.8%	38.6%	2.3%	21.6%	0.7%
Total HIV	44.0%	19.3%	3.0%	31.1%	2.6%



	Latino	Anglo	API	Af Am	Nat Am/ Other
SPA7 Pop	64.8%	24.3%	8.3%	1.9%	0.7%
SPA7 AIDS	72.9%	17.3%	1.7%	7.7%	0.6%
SPA7 HIV	72.0%	12.4%	1.1%	14.0%	0.5%
Total Pop	45.7%	32.7%	12.3%	8.5%	0.7%
Total AIDS	36.8%	38.6%	2.3%	21.6%	0.7%
Total HIV	44.0%	19.3%	3.0%	31.1%	2.6%



	Latino	Anglo	API	Af Am	Nat Am/ Other
SPA8 Pop	33.1%	37.2%	16.1%	12.7%	0.8%
SPA8 AIDS	27.4%	43.0%	2.6%	26.4%	0.6%
SPA8 HIV	25.5%	40.6%	2.5%	31.0%	0.4%
Total Pop	45.7%	32.7%	12.3%	8.5%	0.7%
Total AIDS	36.8%	38.6%	2.3%	21.6%	0.7%
Total HIV	44.0%	19.3%	3.0%	31.1%	2.6%

CO-MORBIDITIES

The data for co-morbidities is derived from several sources, including HARS, OAPP's service utilization data systems, SHAS, and the 2002 Needs Assessment Survey. Detailed demographic and co-morbidity data from the 2002 Need Assessment Survey is shown in Attachment 6.

Substance Use

Initially the HIV/AIDS epidemic was fueled by sexual behavior among gay men and early detection was among gay Anglo men. Other early infections appeared among intravenous drug users, but IDU was never the major mode of transmission in Los Angeles County, and today it still only accounts for about 12% of the epidemic with MSM/IDU representing another 6%. Still, infected drug users are among the most vulnerable populations as substance use is often accompanied by other co-morbidities such as homelessness, mental illness, hepatitis and other STDs, and poverty. In planning for the priority and allocations of Ryan White CARE Act funds to treat HIV/AIDS, different social and economic indicators can indicate greater need.

The co-morbidity of substance use and HIV includes drugs that are typically injected such as heroin and crystal meth, but also includes non-injecting substances such as marijuana and "party drugs" like ecstasy and poppers that have been related to unsafe sexual practices that place individuals at high risk for HIV exposure.

HARS data for 2001 indicates that about 14% of the newly diagnosed AIDS cases and 13% of the living AIDS cases, including MSM and heterosexual IDU, are attributable to injection drug use. SHAS data reports the IDU rate at about 12%, the OAPP service utilization data reports about 10% and the 2002 Needs Assessment data indicate that IDU and MSM/IDU account for about 26% of PLWH/A. The survey data of self-reported drug use further indicates that an additional 21% report using other, non-injection substances. SHAS data suggests a figure of 42% non-injection drug use. Considering the three data sources it is clear that while the current rate of infection among IDUs in the Los Angeles County is relatively low, the overall high prevalence of non-injection substance use suggests a highly vulnerable population to infection and re-infection.

Poverty

Persons living in poverty often cannot afford basic needs such as food and housing, health care or insurance that would pay for health care, or, if they have insurance, the co-pays that often accompany claims. Poverty is related to unemployment, homelessness and substance use, and these, in turn are related to HIV.

According to the 2001 poverty levels, the poverty level for one-person households is $8,590 and 300% of federal poverty level (FPL) is $25,770. For three-person households 100% of the poverty level is $29,260 and 300% FPL is $43,890 (See Attachment 5).

Table 1-4 shows 18% of the Los Angeles County population lives below poverty level. Survey data and census data further reveal that 39% of the Los Angeles County population earns 200% below poverty level or less. As confirmation that HIV and AIDS follow poverty, two areas with the highest infection rates, the Metro and South SPAs, also have the highest poverty levels. Similar to HIV infection rates, poverty rates are also disproportionately high for people of color in Los Angeles County. particularly for African Americans who represent 9.8% of the County's population, yet represent more than 20% of those living in poverty.

Notably, PLWH/A are more likely to be in poverty with 52% of those in the needs assessment survey reporting living below the poverty level. Based on both the OAPP client database and the 2002 Needs Assessment Survey, over 90% of the PLWH/A who receive Ryan White CARE Act-funded care live below 300% FPL, the usual cutoff for receiving CARE Act-funded services. Poverty levels among PLWH/A are further discussed in the demographic section of the needs assessment.

Table 1-4 Poverty Levels

		% Below 100% poverty level
	California	20.1
	Los Angeles County	18.1
Race	Latino	27.0
	Anglo	7.1
	API	13.3
	African American	20.6
	Native Americans	13.9
SPAs	Antelope Valley	12.1
	San Fernando Valley	14.5
	San Gabriel Valley	15.9
	Metro	31.0
	West	12.7
	South	37.0
	East	19.0
	South Bay	17.3
PLWH/A	PLWH/A (survey)	52.4
	PLWH/A (OAPP client database)	NA

Insurance

Table 1-5 shows the insurance status of the population in Los Angeles County and each of the SPAs. It also shows the percentage of PLWH/A with different types of insurance.

Over 30% of the adults in Los Angeles County do not have health insurance, and 20% of the children are uninsured. Los Angeles County has a higher rate of adults uninsured than the state of California. The highest rates of uninsured adults are in the South SPA (47%) and Metro SPA (43.5%), followed by the East SPA (33%). These are the three areas with the highest prevalence of HIV/AIDS, and have large Latino communities, which are much more likely to not have

insurance than other racial and ethnic communities. As shown in Table 1-5, 49% of Latinos are uninsured, compared to 25% of APIs, 19% of African Americans, 18% of Anglos, and 16% of Native Americans.

Based on 2002 Needs Assessment Survey (see NEEDS, UNMET NEEDS, GAPS, AND SERVICES DELIVERY BARRIERS for a detailed discussion of the needs assessment survey), slightly lower percentage (28%) of PLWH/A than the general populations (31%) report that they are uninsured. Those PLWH/A who are insured, however, are much more likely to report MediCal (52%) and Medicare (26%), than private insurance (13%). Those in the OAPP service utilization data are even more likely to be uninsured (44%), reflecting the greater reliance on Ryan White CARE Act-funded programs by uninsured PLWH/A.

Based on the County's SHAS interview data from AIDS cases diagnosed between 2000 and 2002, 30% report that they have no form of medical insurance, including Medicaid. The study population was derived from people in HIV/AIDS outpatient services, and therefore likely under-represents the proportion of people with HIV/AIDS who do not have insurance.

Based on multiple sources, between 30% and 40% of PLWH/A in LA County are likely to be uninsured.

Table 1-5 Insurance

		% adults with no health insurance	% children w/o health insurance	% MediCal	% Medicare	% Private
Gen Pop	**California**	**22.2**	**19.0**			
	Los Angeles County	31.4	20.3	8.6	0.6	59.3
Race	Latino	48.9		9.3	0.2	41.5
	Anglo	18.1		4.9	1.0	75.9
	API	25.2		8.6	-	66.0
	African American	18.8		18.6	1.6	61.0
	Native Americans	16.4		24.4	-	56.5
SPAs	Antelope Valley	20.9	10.2	13.7	1.8	63.7
	San Fernando Valley	27.7	16.9	5.8	0.4	66.1
	San Gabriel Valley	28.6	18.8	8.2	-	62.8
	Metro	43.5	26.9	9.9	0.8	45.8
	West	23.1	17.1	6.1	-	70.8
	South	47.4	27.7	14.7	0.9	37.0
	East	33.2	19.9	8.0	0.6	58.3
	South Bay	26.6	18.1	9.1	1.1	63.2
PLWH/A	PLWH/A (2002 Survey)	28.0	NA	52.0	25.6	12.6
	PLWH/A (OAPP clients)	44.1	NA	18.7	3.3	6.7
	PLWA (SHAS)	30.0	NA	NA	56.0	7.0

STDs

Since the beginning of the AIDS epidemic, researchers consistently have suggested an association between HIV/AIDS and other STDs. Numerous national studies have indicated at least a two-fold to five-fold increased risk for HIV infection among persons who have other STDs.

Table 1-6 summarizes STD rates in the general population, and among PLWH/A.

Table 1-6 STDs (HD = Health District)

STD (rate per 100,000)	1999		2000		2001		PLWH/A (2002)
	LA HD	LB HD	LA HD	LB HD	LA HD	LB HD	
Syphilis	.9	2.4	1.5	4.0	NA	NA	73
Gonorrhea	68.7	118.3	81.4	124.0	84.9	135.5	25

Syphilis

From 1996 through 1999, the numbers of primary and secondary syphilis cases were declining in Los Angeles County. However, since 2000 there has been a major outbreak of primary and secondary syphilis representing an almost 63% increase in the number of cases since 1999. As expected, the PLWH/A in the 2002 Needs Assessment report a much higher syphilis rate of 73, and based on the County's SHAS data, about 22% of the PLWA have had syphilis.

A large syphilis outbreak occurred among MSM in Southern California during January-July 2000 and has continued into 2001. According to the State Report, STD 2000, rates jumped in the Los Angeles Health District from .9 per 100,000 in 1999 to 1.5 per 100,000 in 2000. The Long Beach Health District reported significantly higher levels than the Los Angeles Health District, with 2.4 cases per 100,000 in 1999 and 4 cases per 100,000 in 2000.

As reported in MMRW (Morbidity and Mortality Weekly Report), the largest increase was among MSM. In the first part of 2000, the proportion of primary and secondary (P&S) syphilis cases among MSM increased to 51% from 26% for the same period in 1999. During January-July 2000, 130 case-patients were reported, 66 (51%) of whom were MSM compared with 26 (26%) of 100 for the same period in 1999. Of the 66 MSM case-patients, 15 (23%) had primary syphilis, and 51 (77%) had secondary syphilis. Forty-one (41) MSM case-patients were from Los Angeles County. The high rates have continued through 2001, and raise the issue of unsafe sexual practices and re-infection for PLWA–a potentially serious problem because a new strain of HIV could react differently to medication the patient is currently taking.

Gonorrhea

Like primary and secondary syphilis, gonorrhea rates have climbed since 1999. For Los Angeles County, rates rose from 68.7 in 1999 to 84.9 in 2001. For Long Beach, the rate started at 118.3 in 1999 and increased to 135.5 per 100,000. PLWH/A in the 2002 Needs Assessment report a much lower rate of gonorrhea (25%) than the rate reported by PLWA in the SHAS interviews

(31%). While these self-reported rates are difficult to interpret, a Seattle-based study of MSM accessing HIV and STD clinics also confirmed a lower (10%) prevalence of gonorrhea among HIV positive MSM than among HIV negative MSM (13%). This may suggest a more aggressive and successful treatment of gonorrhea among PLWH/A.

Hepatitis

Hepatitis C

The California Department of Health Services estimates there are approximately 200,000 people (2% of the population) with hepatitis C living in Los Angeles County with an incidence rate in 2000 of .34 per 100,000 population. In 2000, there were 10,044 case reports of HCV infection–including acute, chronic and resolved cases–a 34% increase from 1999. Of those cases, only 10 could be confirmed as acute infections.

The highest risk for the virus is through nasal ingestion of cocaine, intravenous drug use, using shared infected needles in unlicensed tattooing—as occurs in incarceration facilities—and unsterilized tools in body piercing. Findings from the 2002 Needs Assessment reveal that about 15% of PLWH/A have had hepatitis C. Among IDUs this rate is 50%. This is probably an underestimate as CDC estimates that three-quarters of injection drug users are infected with hepatitis C. About one quarter of recently incarcerated and PLWH/A with a history of homelessness report having had hepatitis C.

Hepatitis A

Hepatitis A rates have fluctuated since 1993, ranging from about 10 per 100,000 in 1998 to a high of about 16 per 100,000 in 1997. The 1997 hepatitis A crude rate (16.4 per 100,000 population) in 1997 represented a 10% increase over the 1996 rate of 14.9 per 100,000.

By 2000, the rate of hepatitis A dropped to about 9 per 100,000. SPAs 4, 6, and 7 have the highest rates (9.9, 9.8 and 8.8 per 100,000, respectively), while SPAs 3, 5, and 8 have rates significantly lower than the county average.

Hepatitis B

From 1992 to 1993 there was steep decline in the incidence of hepatitis B in the Los Angeles County. Since then the rate has leveled off and ranged from about one to five cases per 100,000. In 2000, there were 65 cases of hepatitis B reported, with an incidence rate of less than one case per 100,000. Data obtained from the 2000-2002 SHAS interviews indicates that about 3% of the PLWA are co-infected with hepatitis B.

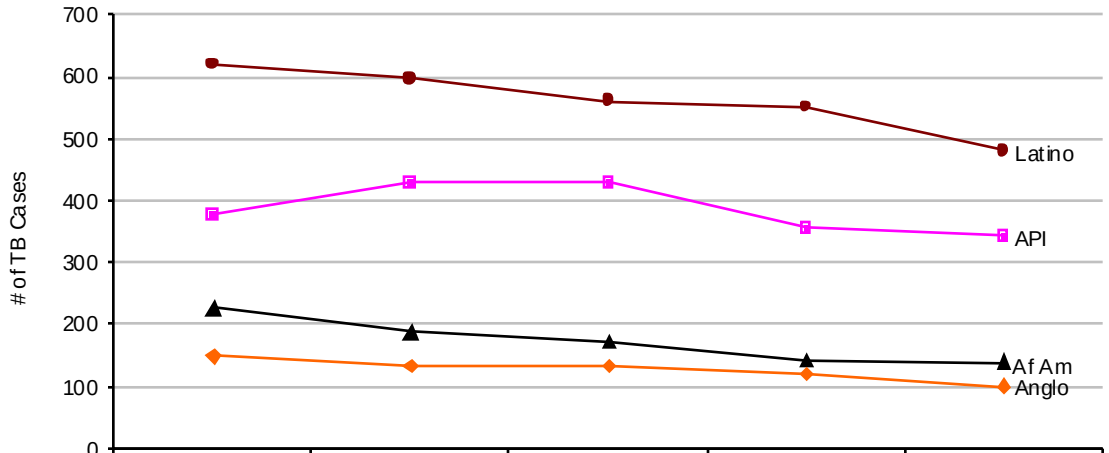
Tuberculosis

Based on Los Angeles County Health Department Data shown in Figure 1-25, since 1996, the overall rate of tuberculosis in Los Angeles County has steadily decreased. However, not all

ethnic populations have experienced the same level of decrease, and with high number of immigrants moving to Los Angeles from high incidence areas overseas, there is a need to carefully monitor the TB rate. In 2000, Latinos accounted for nearly half (45%) of the tuberculosis cases, followed by APIs (32%). However, APIs with a rate of 30.6 per 100,000 and African Americans with a rate of 18.3 per 100,000 are the communities most impacted by tuberculosis. In 2000, about 7% of the individuals with tuberculosis are co-infected with HIV, and about 7% are homeless. Among the 76 homeless individuals who were diagnosed with TB in 2000, 53% were African American.

The distribution of tuberculosis varies by SPA. For instance, in 2000, the Metro SPA, with 272 cases, accounted for more than one quarter of the cases. The San Gabriel Valley and South SPAs each accounted for about 15% of the TB cases.

Figure 1-25 Trends in Tuberculosis by Ethnicity



	1996	1997	1998	1999	2000
Af Am	227	187	172	141	140
Anglo	148	132	132	119	100
API	378	429	428	356	343
Latino	619	597	560	552	482
TOTAL	1,372	1,345	1,292	1,168	1,065

Homelessness

Stable housing is often a prerequisite for a PLWH/A who is trying to adhere to a difficult medical regimen and improve their quality of life. Living in shelters and inconsistent access to food and proper nutrition further aggravates the difficulty adhering to treatment and medications. In many cases, HIV/AIDS is both a cause and a result of homelessness. It is believed that HIV infection in homeless communities varies from 3%to 19.5% with a significantly higher rate of infection in subgroups such as communities of color, intravenous drug users, women and youth. Overall, the Los Angeles County HIV Epidemiology Program estimates that 4.6% of the currently homeless populations are infected with HIV.

The Housing Opportunities for Persons with AIDS (HOPWA) program, enacted as part of the National Affordable Housing Act in 1990, distributes funds based on a federal formula to jurisdictions with the largest number of reported AIDS cases. In 2001, Los Angeles received approximately $9,700,000 in HOPWA funds. HOPWA funds can be used for various housing activities, including capital, supportive services, rental assistance and technical assistance. Capital activities include acquisition, rehabilitation, conversion, new construction and/or leasing. The City of Los Angeles Housing Department (LAHD), the HOPWA grantee for Los Angeles County, has created seven HOPWA program categories with the goal of devising long-term comprehensive strategies for meeting the housing needs of low-income PLWH/A and their families in Los Angeles County. The program categories include 1) a centralized countywide housing information services clearinghouse, 2) emergency housing and meal vouchers, 3) short-term rent, mortgage and utility assistance, 4) housing specialists to assist PLWH/A in locating and maintaining appropriate housing , 5) lease operating and supportive service costs in emergency shelter and transitional housing, 6) supportive services in permanent housing, and 7) scattered site master leasing.

While a small percentage of PLWH/A are currently homeless, according to State estimates, one-third to one-half of people living with HIV/AIDS are either homeless or at risk of becoming homeless. An alarming 50% of individuals with HIV/AIDS are expected to need housing assistance during the course of their illness. It has been reported that few homeless individuals know their HIV status and even fewer are informed about treatment options.

The most recent data on homelessness in California comes from the 1999 Statewide Housing Plan, prepared by the Department of Housing and Community Development (HCD). Annual estimates for Los Angeles County indicate that in the course of one year, there are approximately 236,000 homeless people in the County and up to 84,000 persons are homeless on any given night. Estimates are that up to 50% of homeless adults have severe mental disorders such as schizophrenia, depression and/or bipolar affective disorder. Forty percent (40%) are addicted to both alcohol and drugs, and up to 80% of homeless adults have a concurrent disorder such as alcohol or drug addiction.

Data from the SHAS interviews also reveals that about 10% of the PLWA were either homeless at the time of diagnosis or have become homeless since learning their status. Homeless PLWA from the SHAS interviews are more likely to be African American (45%) and to have heterosexual exposure to HIV (39%), with over 56% reporting substance use. OAPP's service utilization data also shows that about 10% of the PLWH/A have a history of homelessness.

In addition, as reported in 2001 by the Los Angeles County Department of Health Services, HIV Epidemiology, the greatest number of homeless cases (38%) were located in the Metro SPA, a region characterized by high population density, severe poverty and a large number of persons with other risk factors for TB such as HIV infection, injection and non-injection drug use and severe alcohol abuse. The OAPP service utilization data confirms the study's findings and shows that over one third (36%) of the homeless PLWH/A live in the Metro SPA. OAPP's service utilization data shows that the South Bay SPA has the second largest concentration of

homeless PLWH/A, accounting for about 22% of the homeless PLWH/A in the Los Angeles County.

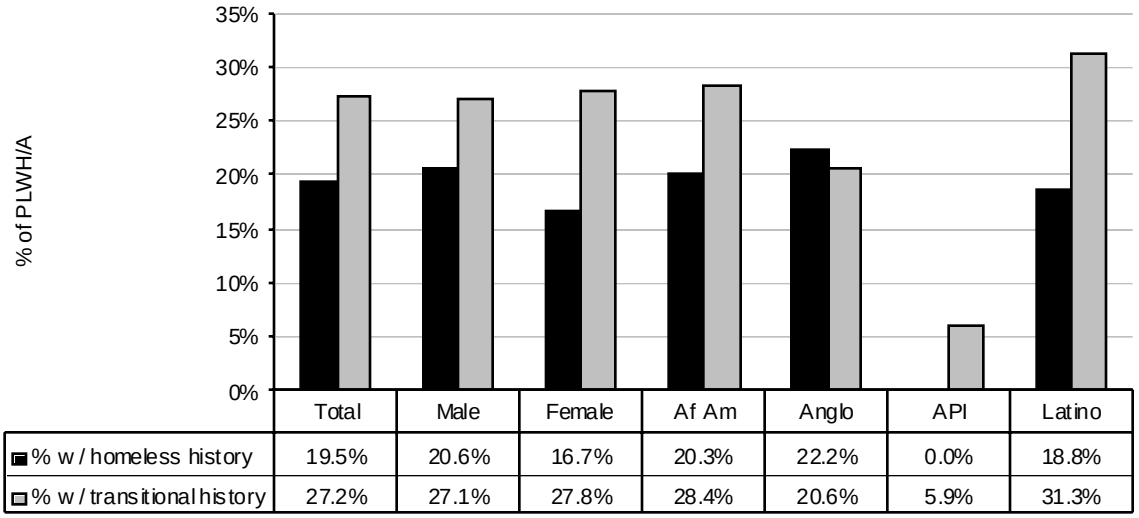
In 2000, fifteen percent (15%) of the individuals newly diagnosed with AIDS were homeless. The 2002 Needs Assessment Survey further supports this finding and indicates that among the PLWA diagnosed in 2000 or later, 19% are currently homeless and an additional 37% report living in some form of transitional housing. Transitional housing includes living in a single room occupancy (SRO) with or without tenancy, living in a group home or residence including residential drug therapy, or a halfway house. The survey data further indicates that the new diagnosed PLWA are more likely to be homeless, as the newly infected are more concentrated among lower-income individuals.

The instability of housing becomes evident when PLWH/A are asked if they have been homeless or in transitional housing in the last two years. Based on the 2002 Needs Assessment, 20% have been homeless sometime in the last two years, and 27% have lived in some form of transitional housing. Overall, about 14% of all PLWH/A interviewed feel that their current housing situation is unstable. Populations that report the highest vulnerability to homelessness are the undocumented, recently incarcerated, PLWH/A in the Antelope Valley and Metro SPAs, and IDUs. African American PLWH/A are more likely to report unstable housing than are PLWH/A from other ethnic populations.

Figure 1-27 and Figure 1-27 based on the 2002 Needs Assessment Survey confirm that:

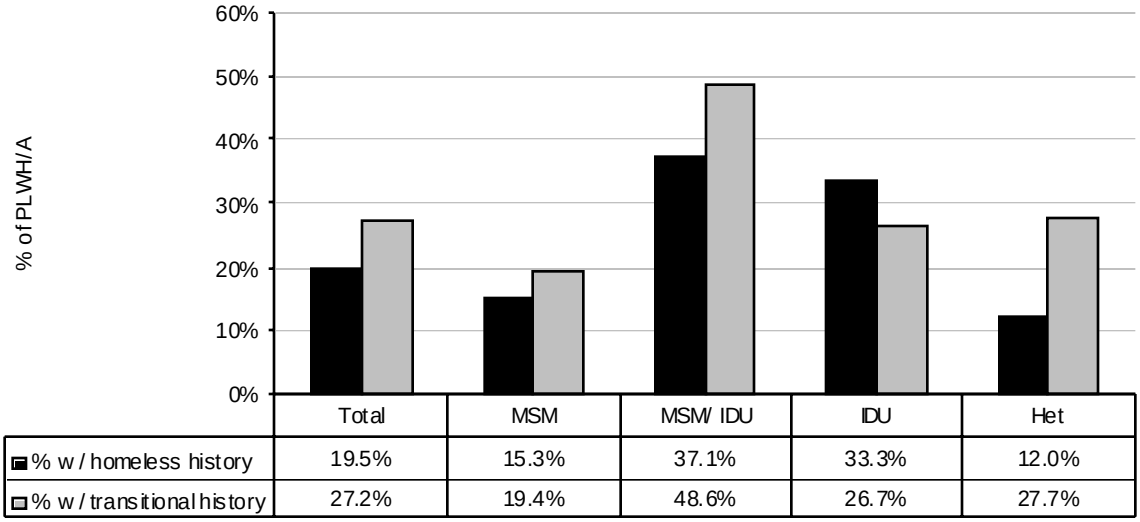
- Women are less likely to have a history of homelessness or living in transitional housing than men or transgender persons. This perhaps reflects the greater availability of government funded housing opportunities or greater availability of family-based resources for women and children.
- APIs (0%) and Latinos (19%) report a much lower incidence of homelessness.
- Among risk groups, IDUs and MSM/IDU are much more likely to have been homeless or lived in transitional housing than MSM or heterosexuals. MSM of color are more likely than Anglo MSM to have a history of unstable housing.
- Recently incarcerated PLWH/A are far more likely to experience a period of homelessness than other populations. Nineteen percent (19%) of all PLWH/A report having a history of being homeless compared to 63% of those who have been incarcerated in the last two years. This may reflect the financial challenges and rules and regulations of public housing one faces after being released from the jail system.
- PLWH are more vulnerable to unstable housing than are PLWA. This may be factor of rules and regulations regarding eligibility for housing based on stage of infection.

Figure 1-26 Homelessness & Transitional Housing by Gender and Mode



	Total	Male	Female	Af Am	Anglo	API	Latino
% w / homeless history	19.5%	20.6%	16.7%	20.3%	22.2%	0.0%	18.8%
% w / transitional history	27.2%	27.1%	27.8%	28.4%	20.6%	5.9%	31.3%

Figure 1-27 Homelessness & Transitional Housing by Ethnicity



	Total	MSM	MSM/ IDU	IDU	Het
% w / homeless history	19.5%	15.3%	37.1%	33.3%	12.0%
% w / transitional history	27.2%	19.4%	48.6%	26.7%	27.7%

Impact of the Health Crisis

Faced with an $800-million budget deficit, the Los Angeles County Department of Health Services confronts the daunting task of restructuring the county's health care system. There is no question that the county lacks the money to continue with business as usual. At the time of this plan's adoption, the Board of Supervisors' current plan is to close all but the seven comprehensive clinics, convert High Desert Hospital to an outpatient facility, and combine administration at Harbor UCLA Medical Center and Martin Luther King/Charles R. Drew Medical Center.

Even before the closings, current resources provide less than 11,000,000 ambulatory visits for the uninsured, compared to an estimated 12,500,000 to 19,000,000 annual visits required

annually. Unmet need for the uninsured is expected to rise exponentially in future years, as the County's Department of Health Services may have to close hospitals and clinics in the face of looming budget deficits (in the hundreds of millions of dollars). More than 350,000 low-income people in Los Angeles County (most with little or no health insurance) use community-based care clinics each year. However, Los Angeles County has fewer free and community clinics per 100,000 people than anywhere else in California.

The restructuring plan notes, "it is important to recognize that today's County-supported health system faces high demand, limited resources, and a fiscal situation that requires DHS to reduce capacity. This set of decisions will lead, regrettably, to reduced access to care for some individuals." It continues, "The forecasted $326.6 million deficit for fiscal year 2003-04, and its growth to $709.4 million by fiscal year 2005-06, requires DHS to initiate service curtailments to improve its fiscal stability. Preliminary estimates suggest that at a minimum, DHS will need to reduce inpatient services by approximately 29%, outpatient services by 16%, and budgeted positions by 18%. The plan notes that there will be no direct cuts in HIV/AIDS grant-funded services and it cannot reduce the County's contribution to those services due to Ryan White CARE Act Maintenance of Effort (MOE) legislative requirements. Still as PLWH/A are increasingly unable to seek community health care and inpatient services, there is likely to be a measurable burden of service shifted to HIV/AIDS grant-funded clinics.

Several steps are planned to make the system more efficient. Among them, a process will be undertaken to stratify patients according to risk and health condition and match them to appropriate levels of care, thus ensuring that patients with routine or episodic conditions are not seen in health care settings more sophisticated than clinically indicated.

Over the next several months it is important that the Commission take a proactive role in assuring that PLWH/A are appropriately stratified by need and the importance of prevention, early detection and treatment is emphasized. While further study is necessary to quantify the impact of the plan, given that the restructuring is in process, the Commission will provide positive input into the process to assure that PLWH/A who depend upon the County health care system are able to receive needed services.

NEEDS, UNMET NEEDS, GAPS, AND SERVICES DELIVERY BARRIERS

Service Categorization

This section draws from several sources of data including:

- The 2002 Needs Assessment Survey was responded to by 246 PLWH/A. The survey over-represented women and Latinos, but otherwise is relatively close to the profile of all people living with HIV/AIDS. Consumers were asked to rank their awareness of need, demand, and utilization for 33 services. Table 1-7 below shows the services included in the 2002 Consumer Survey (see Attachment 1) as they fit in the five Continuum of Care categories. In general, this is the most current and complete estimate of stated need by PLWH/A. Secondary sources of information were included as available from the sources noted below.
- Supplement to HIV and AIDS Surveillance Project (SHAS) 2000 – 2002 database of PLWA (N=367). The SHAS data also over-represents women, and communities of color. While the SHAS questionnaire asks about service need, in some cases it asks if PLWA have needed "assistance in finding" the services. Therefore, the response is not a direct estimate of the need for the service, but rather an estimate of the participants feeling that they need assistance.
- The OAPP service utilization [Information Management of AIDS Clients and Services (IMACS)/Casewatch and Toolbox] which is the main client database used to aggregate client demographics and utilization of services from CARE Act-funded providers. According to these databases there are 19,149 unduplicated clients, including HIV-negative collaterals and pediatric AIDS cases.

Table 1-7 Needs Assessment Survey Services (2000)

1. PRIMARY HEALTH CARE CORE
Outpatient medical care*^
Medical care by a specialist
Outpatient mental health services*^
Residential mental health services
Nutrition education and counseling
Dental care*^
Outpatient substance abuse services^
Residential substance abuse services
Detox and/or methadone maintenance
Medical case management
Hospice services (in-home and residential)^
Home heath care*^
Complementary care
Drug reimbursements
Health education/Risk Reduction*^

* Services asked about in SHAS database

^ Services asked about in the OAPP service utilization data.

2. REMOVAL OF BARRIERS
Food pantry or food bank*^
Home-delivered meals
Food vouchers
Rental subsidies
"Independent" housing (e.g. through Section 8 or HOPWA)
Residential housing or group home
Emergency or transitional housing
Van transportation*^
Taxi vouchers or bus tokens
Day care for children*^
Emergency financial assistance^
3. PATIENT CARE COORDINATION
Psychosocial case management*^
Housing information services*^
4. ECONOMIC WELL-BEING
Health insurance continuation
Legal services
Employment Assistance
5. ENHANCEMENT SERVICE OPTIONS
Peer counseling^
Adult day care

Most Needed Services

For each of the 33 service categories shown in Table 1-7 PLWH/A were asked if they "needed the service in the past year" (see Q. 38 in the 2002 Needs Assessment Survey). A comparison, when possible, was made between the 2002 Needs Assessment Survey and the SHAS database. SHAS asks their participants if they needed any of thirteen services listed in the past twelve months. (See Attachment 7 for needs by subpopulations.)

Top Rated Needs

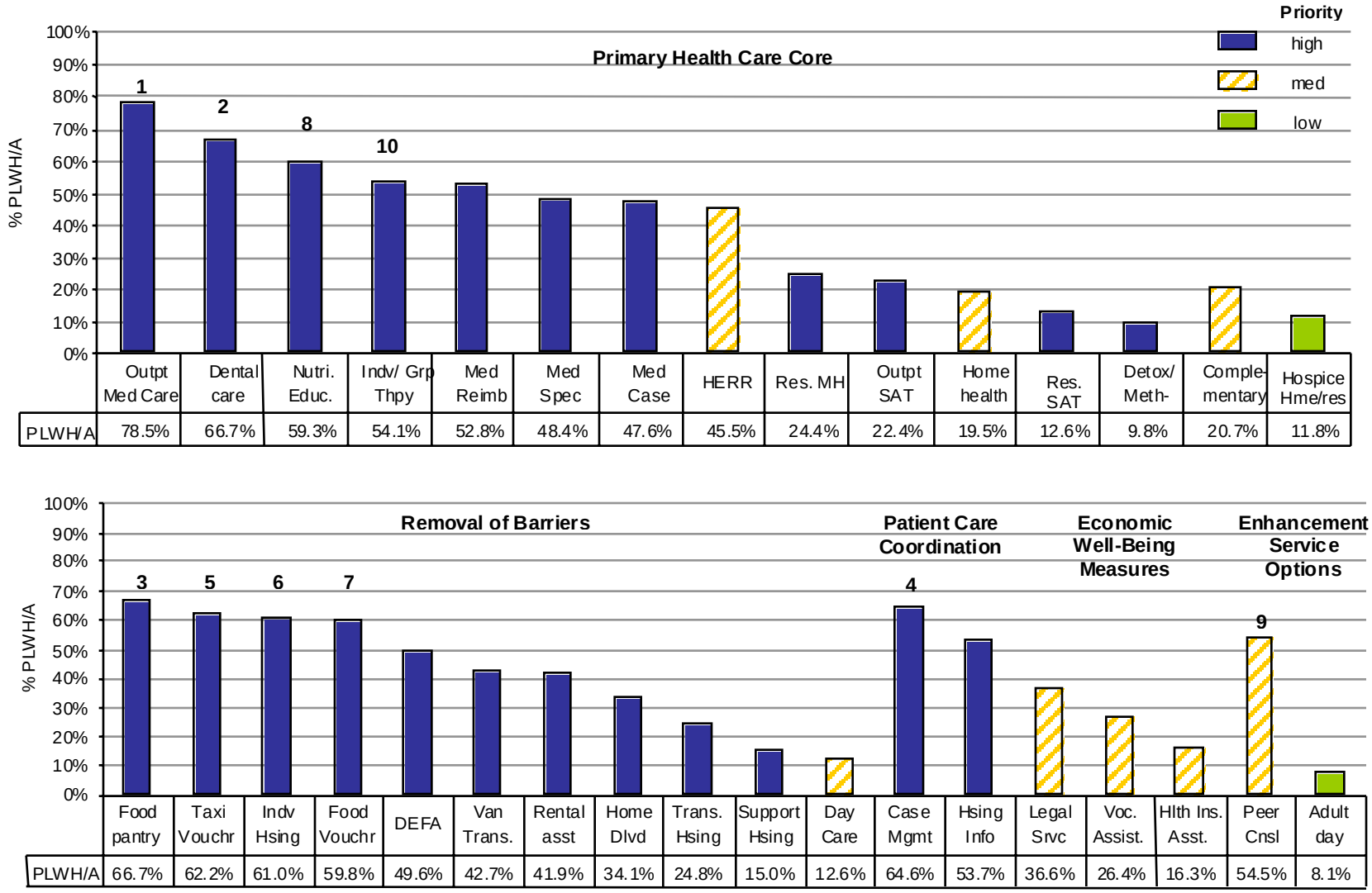
The percentage of the PLWH/A sample needing the service is shown in Figure 1-28. The graph is presented by the continuum of care priorities. Within the priorities, services are ranked, first, by the Commission's 2002 ranking of the services and then by the percentage of PLWH/A who report they needed the service in the past year. The numbers on top of some bars represent the ranking of the top ten service categories, regardless of overall priorities.

Figure 1-28 indicates that:

- The top two most needed services are within the primary health care core: 1) outpatient medical care (78.5%) and 2) dental care (67%).
- Ten percent (10%) more PLWA in the Needs Assessment Survey said they needed medical care (81%) and dental care (71%). When SHAS asked if PLWA needed assistance finding outpatient care and dental care, 16% of the PLWA said they needed assistance finding a doctor for ongoing medical services and 27% said they needed assistance finding dental services. This is likely to reflect those who need, but could not find or were not satisfied with these services.
- In the 2002 Needs Assessment Survey, food service is ranked third, with about two-thirds of PLWH/A reporting a need for the service. About 64% of PLWA said they need food pantry services. Food vouchers, one of the subservices within the food service category, is ranked seventh by the PLWH/A (60%) and ranked twelfth by PLWA (52%). In SHAS about 25% of the PLWA said that they needed assistance finding food services (including meals), and this is likely to reflect those who could not find food services or were dissatisfied with food services.
- Case management is ranked fourth by PLWH/A (64%). It is ranked fourth by PLWA with 64% saying they need case management services. It is ranked as the highest need by SHAS PLWA (47%).
- Taxi vouchers or bus tokens are ranked fifth by PLWH/A (62%), and ranked seventh by PLWA (58%) in the 2002 Needs Assessment Survey. Based on SHAS data, transportation is ranked third (42%).
- Out of five housing subservices, the need for independent housing (provided through Section 8, HOPWA or other state agency) is ranked sixth (61%) by PLWH/A in the 2002 Needs Assessment Survey. It is also ranked sixth (62%) by the PLWA. Housing information services is needed by a quarter of the SHAS PLWA.

- Nutritional counseling and education is ranked eighth (59%) in the 2002 Needs Assessment Survey.
- An enhancement service, peer counseling/drop-in groups (ranked ninth, 55%) and primary health care mental health service, outpatient individual/group mental health counseling ranked tenth with 54% expressing a need. They ranked tenth (54%) and eighth (58%), respectively among PLWA. Thirty-two percent (32%) of the PLWA in SHAS expressed a need for mental health services, ranking it fourth among the13 services.
- Notably, the expressed need for substance abuse treatment appears to be relatively low with outpatient substance abuse treatment and counseling ranked 24 (22%) out of 33 services. Even though a minimum of 25% of the sampled PLWH/A have a history of injection drug or other substance use, a maximum of 23% of those populations expressed a need for the service.
- Complementary care is ranked by the Commission as a medium priority and this survey data shows that a fifth (21%) of the PLWH/A expressed a need for the service in the 2002 Needs Assessment Survey.
- At 12%, Hospice care is in least demand by PLWH/A in the 2002 Needs Assessment Survey, and thus was prioritized low by the Commission. Not surprisingly, 17% of the symptomatic PLWH/A expressed a need for the service. Notably, respondents were asked to rate in-home and residential hospice care and collectively, hospice care may have been broadly interpreted by some PLWH/A as home care rather than end-stage care for the critically ill.

Figure 1-28 Ranked Service Needs

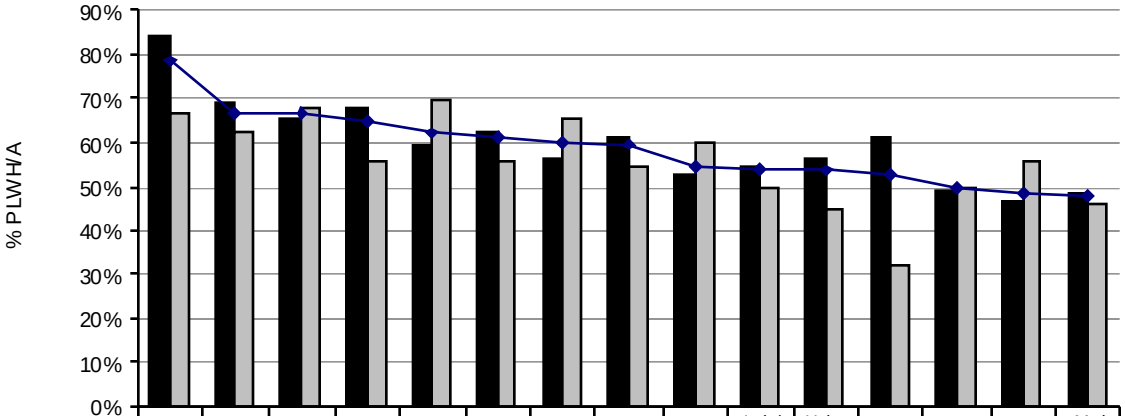


Top Service Needs: Gender Differences

Based on the 2002 Needs Assessment Survey, selected services indicate a large gender difference. As shown in Figure 1-29, women place a higher priority on taxi and food vouchers than all PLWH/A.

- The top three needs for women living with HIV and AIDS are taxi vouchers (69%) followed by food pantry (68%) and outpatient medical care (67%). For female PLWA, the top needs are dental care (69%), outpatient medical care (66%), and peer counseling (66%). In the SHAS data, the top three needs are transportation (52%), social services for assistance in getting health insurance or financial counseling (41%), and case management (38%). The reason that women express a greater need for peer counseling will be investigated in ongoing needs assessment studies, but many may be related to the demonstrated need by women for services which inform them of and help them access other services.
- Women are more likely than men to report a need for food vouchers. They say they need more interaction with peers for peer counseling, and also have a greater need than men for medical specialists (probably referring to OB/GYN services)[4].
- Men express higher need than women for nine out of 15 services. The top three service needs for men living with HIV/AIDS are medical care (84%), dental care (69%), and case management (68%). The top three among male PLWA have the same top needs. In the SHAS data, the top three needs for male PLWA are case management (47%), social services (44%), and transportation (42%).
- Men are more likely to say they need independent housing, nutritional education, mental health, and housing information services. The largest difference between men and women is the expressed need by men for medication reimbursement. This is probably because women are more likely to be insured outside/beyond of the Ryan White CARE Act.

Figure 1-29 Top Service Needs by Gender



	Med Care	Dental care	Food pantry	Case Mgmt	Taxi Vouchr	Indv Hsing	Food Vouchr	Nutri. Educ.	Peer Cnsl	Indv/ Grp Thpy	Hsing Info Srvc	Med Reimb	DEFA	Med Spec	Med Case Mgmt
Male (N=170)	84.1%	68.8%	65.3%	68.2%	59.4%	62.4%	56.5%	61.2%	52.4%	54.7%	56.5%	61.2%	48.8%	46.5%	48.2%
Female (N=72)	66.7%	62.5%	68.1%	55.6%	69.4%	55.6%	65.3%	54.2%	59.7%	50.0%	44.4%	31.9%	50.0%	55.6%	45.8%
Sample (N=246)	78.5%	66.7%	66.7%	64.6%	62.2%	61.0%	59.8%	59.3%	54.5%	54.1%	53.7%	52.8%	49.6%	48.4%	47.6%

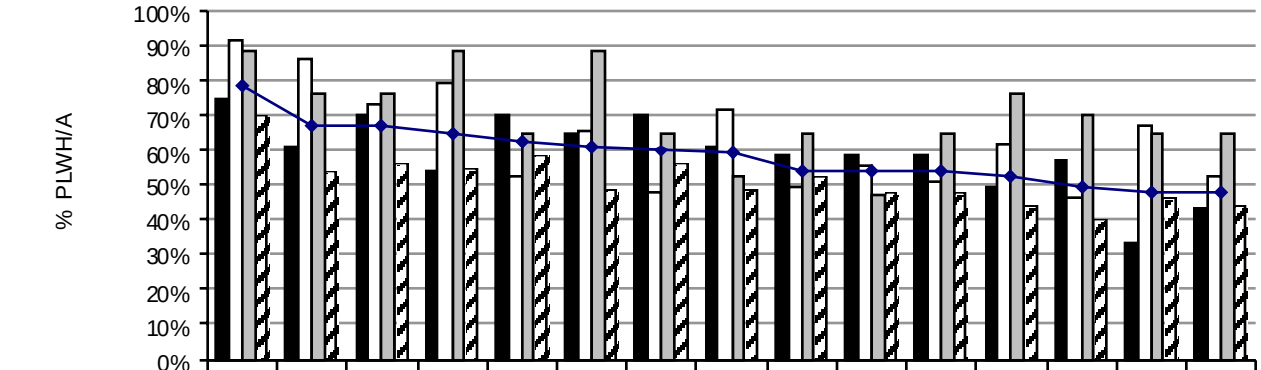
[4] OB/GYN was included as a "Medical Specialist" in the consumer survey but it is part of regular medical service in the funding category.

Top Service Needs: Ethnic/Racial Differences

Figure 1-30 shows the ethnic/racial differences among the top ranked services. Service needs vary by PLWH/A of different ethnicities. In general, African Americans and Latinos report lower rates of need in comparison to Anglo and API PLWH/A. However, they report a higher need for housing information services. Some have speculated that the variance in expressed need is due to lower expectation for service by communities of color.

- The top three expressed needs for African American PLWH/A are medical care (78%), food vouchers (71%), and dental care (65%). As with the survey data, African Americans express a smaller need in the SHAS data with their highest need being transportation (42%). They are more likely to report a higher need for peer counseling and housing information services (along with Latinos) and mental health services (along with Anglos).
- In the 2002 Needs Assessment Survey, the top three needs of Anglos living with HIV/AIDS are medical care (92%), dental care (86%) and case management (79%). Anglos living with AIDS have the same top three needs as the Anglo PLWH/A. In the SHAS data, case management is their highest need (50%). They are more likely to report needing nutritional education and counseling (along with African Americans and Latinos) and medical specialists (along with APIs).
- The top three needs for APIs are medical care, case management, and independent housing (each 88% of the population). They report a greater need than other ethnic groups for medication reimbursement (along with Anglos), direct emergency financial assistance (DEFA), and medical case management.
- Latinos' top three needs mirror those of African American PLWH/A. They are medical care (70%), taxi vouchers/bus tokens (59%), and food services (tied between food vouchers and food bank, each at 56%). There is no service they express a higher need for than any other ethnic group. For Latinos living with AIDS, their top three needs are medical care (70%), dental care (60%) and medication reimbursement (58%). In the SHAS data, Latinos report a need for social services for assistance in getting health insurance or financial counseling (52%), case management (50%) and transportation (45%). Amongst the ethnic groups in the SHAS data, Latinos report the highest need for assistance in getting medical care or finding a doctor (18%). In self-reporting surveys, Latinos often indicate a lower need for services, and this is likely due to lower expectations and the perception of lack of eligibility.

Figure 1-30 Top Service Needs by Ethnicity



	Med Care	Dental care	Food pantry	Case Mgmt	Taxi Vouchr	Indv Hsing	Food Vouchr	Nutri. Educ.	Peer Cnsl	Indv/ Grp Thpy	Hsing Info Srvc	Med Reimb	DEFA	Med Spec	Med Case Mgmt
Af Am (N=74)	74.3%	60.8%	70.3%	54.1%	70.3%	64.9%	70.3%	60.8%	58.1%	58.1%	58.1%	50.0%	56.8%	33.8%	43.2%
Anglo (N=63)	92.1%	85.7%	73.0%	79.4%	52.4%	65.1%	47.6%	71.4%	49.2%	55.6%	50.8%	61.9%	46.0%	66.7%	52.4%
API (N=17)	88.2%	76.5%	76.5%	88.2%	64.7%	88.2%	64.7%	52.9%	64.7%	47.1%	64.7%	76.5%	70.6%	64.7%	64.7%
Latino (N=80)	70.0%	53.8%	56.3%	55.0%	58.8%	48.8%	56.3%	48.8%	52.5%	47.5%	47.5%	43.8%	40.0%	46.3%	43.8%
Sample (N=246)	78.5%	66.7%	66.7%	64.6%	62.2%	61.0%	59.8%	59.3%	54.5%	54.1%	53.7%	52.8%	49.6%	48.4%	47.6%

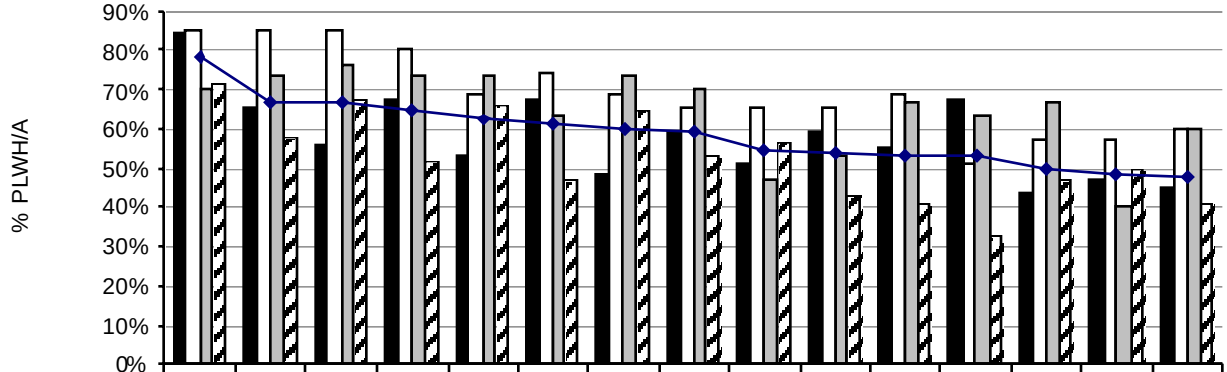
Top Service Needs: Risk Group Differences

Figure 1-31 shows the risk group differences among the top ranked services. In general, MSM/IDU show the highest need for a number of services, and heterosexuals report the lowest needs in both the 2002 Needs Assessment Survey and the SHAS data.

- The top three needs for MSM PLWH/A are medical care (85%), independent housing and case management (both at 67%). MSM have a higher need for medication reimbursement and outpatient mental health services. MSM PLWA also have a high need for dental care and medication reimbursement (67%). The highest need for MSM PLWA according to the SHAS data is case management (48%).
- In the 2002 Needs Assessment Survey, the top three needs for MSM/IDU PLWH/A and PLWA are medical care, dental care, and food pantry (each at 86%). They have a higher need for case management, independent housing, housing information services (along with IDUs) and rental assistance. In the SHAS data, their highest needs are case management (73%), mental health (57%) and dental services (51%). Also in the SHAS data, they have the highest percentage of PLWA needing assistance finding a doctor for ongoing medical services (24%). Note, substance abuse services were not included in the SHAS survey.
- The top three needs for IDU PLWH/A are food pantry (77%), case management and dental care (both at 74%). They rank medical care as their sixth most needed service. They have the highest need for taxi vouchers/bus tokens, food vouchers, nutrition education and direct emergency financial assistance. According to SHAS data, the highest need for PLWA is case management (49%).

- The top three needs for heterosexual PLWH/A are medical care (71%), food pantry (68%) and taxi vouchers/bus tokens (66%). They have a higher need for peer counseling and medical care specialists (particularly because women account for the majority of heterosexuals and OB/GYN was listed as a medical specialty). Overall, heterosexuals may have low needs because the majority are women and they may be getting their services elsewhere. Other than medical care, heterosexual PLWA have dental care (69%) and medical care with a specialist (61%). According to SHAS, heterosexual PLWA have the greatest need for social services for assistance in getting health insurance or financial counseling (53%), corresponding to the expressed need of women.

Figure 1-31 Top Service Needs by Risk Group



	Med Care	Dental care	Food pantry	Case Mgmt	Taxi Vouchr	Indv Hsing	Food Vouchr	Nutri. Educ.	Peer Crsl	Indv/ Grp Thpy	Hsing Info Srvc	Med Reimb	DEFA	Med Spec	Med Case Mgmt
MSM (N=98)	84.7%	65.3%	56.1%	67.3%	53.1%	67.3%	48.0%	59.2%	51.0%	59.2%	55.1%	67.3%	43.9%	46.9%	44.9%
MSM/IDU (N=35)	85.7%	85.7%	85.7%	80.0%	68.6%	74.3%	68.6%	65.7%	65.7%	65.7%	68.6%	51.4%	57.1%	57.1%	60.0%
IDU (N=30)	70.0%	73.3%	76.7%	73.3%	73.3%	63.3%	73.3%	70.0%	46.7%	53.3%	66.7%	63.3%	66.7%	40.0%	60.0%
Het (N=83)	71.1%	57.8%	67.5%	51.8%	66.3%	47.0%	65.1%	53.0%	56.6%	43.4%	41.0%	32.5%	47.0%	49.4%	41.0%
Sample (N=246)	78.5%	66.7%	66.7%	64.6%	62.2%	61.0%	59.8%	59.3%	54.5%	54.1%	53.7%	52.8%	49.6%	48.4%	47.6%

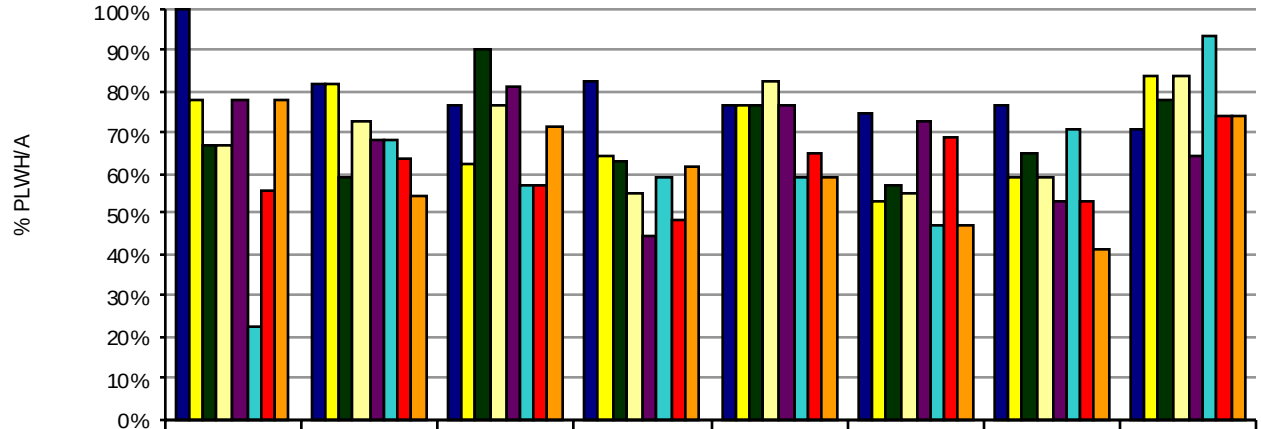
Top Service Needs: SPAs

Figure 1-32 shows the top eight needed services by the total 2002 Needs Assessment Survey PLWH/A sample across the eight SPAs. All SPAs rated outpatient medical care within their top three most needed services except the South Bay-Long Beach SPA, which rated it sixth. Dental care was also on a majority of the top three lists.

Above average need for services existed for medication reimbursement in San Fernando Valley and East SPAs; DEFA in Antelope Valley and South Bay SPAs; medical specialty in San Fernando Valley, Metro, and West SPAs; and housing information services in San Gabriel Valley, East, and South Bay.

Antelope Valley has a higher need for medication reimbursement, taxi voucher and nutrition education. San Fernando Valley has a higher need for dental. In the 2002 survey, San Gabriel Valley PLWH/A reports a higher need for food pantry and taxi vouchers/bus tokens and in the SHAS data San Gabriel Valley PLWA report a high need for social services (61%) and case management (58%). West SPA PLWH/A have a higher need for case management services. South Bay SPA PLWH/A have a higher need for independent housing, case management (along with West SPA), dental care (along with San Fernando Valley SPA), food vouchers, housing information services, and DEFA. Metro, South and East SPA PLWH/A report no particular high need in the 2002 Needs Assessment Survey data. The SHAS data shows that Metro SPA PLWA have a high need for case management (60%).

Figure 1-32 Top Service Needs by SPA



	1 - AV	2 - SF	3 - SG	4 - Metro	5 - West	6 - South	7 - East	8 - S Bay
Med Care	100.0%	81.8%	76.2%	82.1%	76.5%	74.5%	76.5%	71.0%
Dental Care	77.8%	81.8%	61.9%	64.1%	76.5%	52.9%	58.8%	83.9%
Food Pantry	66.7%	59.1%	90.5%	62.8%	76.5%	56.9%	64.7%	77.4%
Case Mgmt	66.7%	72.7%	76.2%	55.1%	82.4%	54.9%	58.8%	83.9%
Taxi Vouchr	77.8%	68.2%	81.0%	44.9%	76.5%	72.5%	52.9%	64.5%
Indv Hsing	22.2%	68.2%	57.1%	59.0%	58.8%	47.1%	70.6%	93.5%
Food Vouchr	55.6%	63.6%	57.1%	48.7%	64.7%	68.6%	52.9%	74.2%
Nutri. Educ.	77.8%	54.5%	71.4%	61.5%	58.8%	47.1%	41.2%	74.2%

Top Service Needs by Special Populations

Stage of Infection

Symptomatic PLWH/A have a higher need for nutrition education and medication reimbursement. Symptomatic PLWH have a higher need for food vouchers and direct emergency financial assistance.

Asymptomatic PLWA have relatively low needs. While medical care is ranked highest among symptomatic PLWH/A and asymptomatic PLWA, asymptomatic PLWH ranks it second after case management.

Undocumented PLWH/A

Medical care is not the priority for the undocumented PLWH/A–they rank it 8th. Their top three needed services are independent housing, case management and medical case management. They report higher than average needs for legal services (due it is assumed to their need for legal assistance with immigration-related issues).

Women of Childbearing Years

The top three services needed by women of childbearing years (WCB) are outpatient mental health services, taxi vouchers/bus tokens, and independent housing. They rank medical care services fourth. They report a higher than average need for direct emergency financial assistance.

Recently Incarcerated

The top three service needs for the recently incarcerated are mental health services, case management, and food services (vouchers and pantry). They rank medical care as seventh. Recently incarcerated PLWH/A report higher than average needs for taxi vouchers/bus tokens, housing services (information and independent housing), peer counseling, legal services, substance abuse counseling and employment assistance. Those with a history of being incarcerated rank their needs low in SHAS. Their top three needs are case management (51%), transportation (46%) and social services (42%).

Homeless

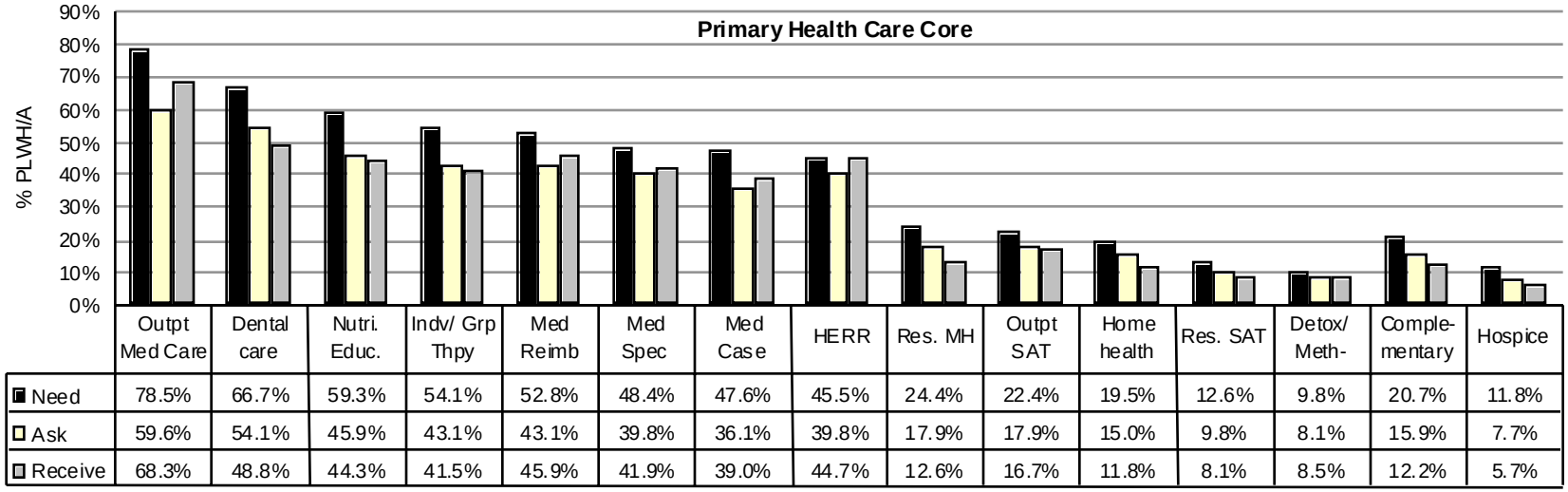
The top three services needed by homeless PLWH/A are housing information, mental health and taxi vouchers/bus tokens. They rank medical care fifth in need tied with independent housing. They indicate a greater than average need for food services (vouchers and pantry) case management, peer counseling, DEFA, substance abuse counseling, rental assistance and employment assistance. Their needs match those reported in SHAS with their top three being transportation (65%), case management (58%) and housing information services (55%).

Asking For and Receiving Services

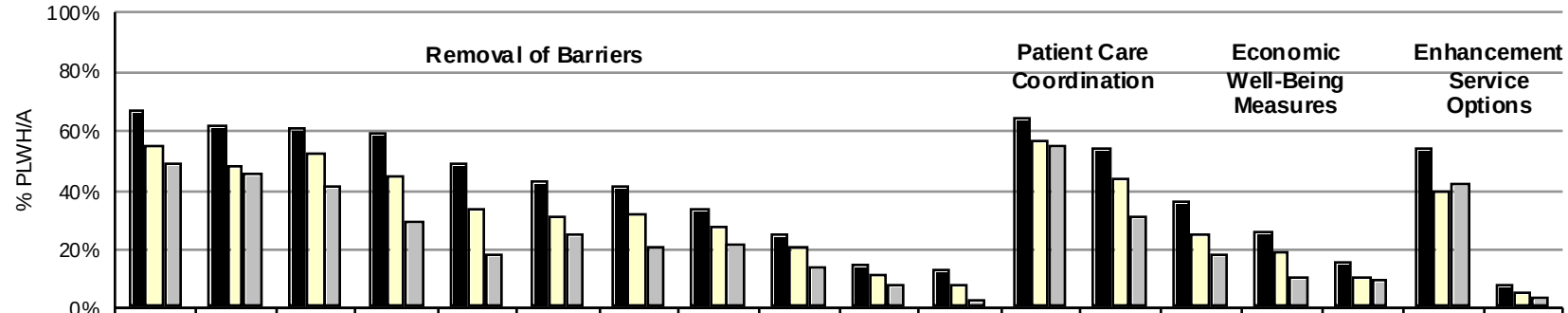
Participants in the survey were instructed to indicate whether they had asked for each of the 33 services in the past year, and whether they received the service. (See Attachment 8 2002 Survey - Services Asked and Attachment 9 2002 Survey - Services Received) As shown in Figure 1-33, expressed need, reported demand (asking for a service) and reported utilization (receiving a service) follow a similar, but not identical pattern. Figure 1-33 indicates that:

- Expressed need is higher than either the reported demand or utilization for each service.
- Demand is usually greater than utilization, with the exception of outpatient medical care, peer counseling, medication reimbursement, medical care with a specialist, medical case management and HERR.
- The demand for services follows reported need, with the exception of outpatient medical care, DEFA and peer counseling, where PLWH/A are considerably less likely to ask for them than other top ranked services.
- The difference in the rank order of utilization and need reflects the much lower utilization of primary health care core services, including medical care with a specialist, outpatient medical care, nutrition education, home health care, and dental care. There is also low utilization of health insurance continuation.
- While 26% of the PLWH/A sampled report having an IDU history and 20% report a non-IDU history, substance abuse services, including outpatient and residential substance treatment, is used by well under 20% of PLWH/A.
- Thirty-five percent (35%) of the PLWH/A report significant adherence problems (skipping medication more than twice a month or stopping medications) and the demand and utilization of medical case management/adherence support is at an equivalent percentage.

Figure 1-33 Consumer Need, Demand, & Utilization



	Outpt Med Care	Dental care	Nutri. Educ.	Indv/ Grp Thpy	Med Reimb	Med Spec	Med Case	HERR	Res. MH	Outpt SAT	Home health	Res. SAT	Detox/ Meth-	Comple-mentary	Hospice
Need	78.5%	66.7%	59.3%	54.1%	52.8%	48.4%	47.6%	45.5%	24.4%	22.4%	19.5%	12.6%	9.8%	20.7%	11.8%
Ask	59.6%	54.1%	45.9%	43.1%	43.1%	39.8%	36.1%	39.8%	17.9%	17.9%	15.0%	9.8%	8.1%	15.9%	7.7%
Receive	68.3%	48.8%	44.3%	41.5%	45.9%	41.9%	39.0%	44.7%	12.6%	16.7%	11.8%	8.1%	8.5%	12.2%	5.7%



	Food pantry	Taxi Vouchr	Indv Hsing	Food Vouchr	DEFA	Van Trans.	Rental asst	Home Dlvd	Trans. Hsing	Support Hsing	Day Care	Case Mgmt	Hsing Info	Legal Srvc	Voc. Assist.	Hlth Ins. Asst.	Peer Cnsl	Adult day
Need	66.7%	62.2%	61.0%	59.8%	49.6%	42.7%	41.9%	34.1%	24.8%	15.0%	12.6%	64.6%	53.7%	36.6%	26.4%	16.3%	54.5%	8.1%
Ask	54.9%	48.4%	52.8%	45.1%	33.3%	31.3%	32.1%	27.6%	21.1%	11.8%	7.7%	56.9%	43.9%	24.8%	19.1%	10.2%	39.4%	5.7%
Receive	48.8%	45.5%	41.5%	29.7%	18.3%	24.8%	21.1%	21.5%	14.2%	8.5%	2.8%	55.3%	30.9%	18.3%	10.6%	9.4%	42.0%	3.7%

Table 1-8 below shows the service utilization reported in three datasets for comparable services. The figures are always not comparable because wording is different and they are different samples. Each report utilization tells a different story. In some cases there was not question about a service and that is noted by a dash mark.

The 2002 Need Assessment Survey (N=246) was sampled from the focus forums and supplemented with intercept interviews at providers. They represent the most needy PLWH/A. The survey data is one-third female, more than two-thirds people of color, and one-third heterosexuals with an over-sample of PLWH/A that actively use and need care services. They were asked broad utilization questions about services and not limited to CARE Act-funded services or providers.

The SHAS study is solely representative of PLWA and a nearly two-thirds of the sample is Latino. Under the SHAS data column, the dash marks notes that data was either not available or the phrasing for the service item was not compatible to the other databases. For example, for outpatient medical care, SHAS asks if the participant received assistance in finding a doctor for ongoing medical services, and thus is not reported here because it asks if the respondent needed assistance receiving the services, not if they received the services.

The fourth column of data in Table 1-8 also shows the frequency of service utilization from OAPP's service utilization data system. Due to varieties in service units, it is simply marked as the number of units utilized on average by the consumer.

There are differences between the utilization figures reported in the three datasets. One explanation could be the difference of the dataset demographics. The OAPP service utilization data would be more representative of the community need as a whole considering it is a uniform reporting system.

The OAPP service utilization data collection system of more than 19,000 PLWH/A is perhaps the most accurate reading of utilization for CARE Act-funded services. The last column reports the mean number of units received by the client. The noted challenge of OAPP's data system is the highly variable quality of input from providers.

Table 1-8 shows that the outpatient medical care is the most utilized service in the continuum of care. The estimate, at between 63% and 68%, may seem low, but it includes both people living with HIV/AIDS and from early to late stage of infection. The data was limited to the past year.

Case management is the next most utilized service. The lower percentage of case management clients in the OAPP database was due, in part, to limitation of OAPP's data collection system; currently services rendered are included under the service category, but not cross-indexed if they were a result of case management. OAPP's service utilization data system will be rectified to better represent the impact of case management services, and will further investigated in subsequent years.

The next most utilized service by participants of the Needs Assessment Survey and the OAPP service utilization database is food services (49% and 19% respectively). There are two reasons for the difference in percentage utilization. First, the 2002 Needs Assessment Survey does not limit the utilization to CARE Act-funded services, and there are many food banks funded by other sources. Second, since much of the sampling from the 2002 Needs Assessment Survey was from agencies serving the poor, it is not surprising that their utilization is higher than a more representative sample of PLWH/A. This would suggest that non-CARE Act-funded food services meet a substantial need.

Dental care, HERR and peer counseling are reported as the fourth, fifth, and sixth services utilized by PLWH/A participating in the 2002 Needs Assessment Survey. These services are largely funded outside the CARE Act service delivery system, with only 9% of those in the OAPP client database reporting dental care, while almost 50% of those in the 2002 Needs Assessment Survey reporting dental care. HERR is largely funded by prevention funds, and peer counseling is provided largely by private funds.

Over 40% of the participants in the Needs Assessment Survey report mental health services. Usage is relatively high in the OAPP service utilization database with 19% saying they use the service. Among PLWA, SHAS suggests the utilization is higher. Regardless of source, this core service is among the most utilized reported by PLWH/A.

The overall message of this data is supportive of the providing services in a way suggested by the continuum of care. However, another message in this data is the need for more uniform data collection, in order to get comparable data from different sources, and greater quality assurance for providers entering data into the OAPP service utilization database.

Table 1-8 Comparison of Service Utilization between 2002 Survey, SHAS, & OAPP Service Utilization Data

	2002 Survey N=246	SHAS N=367	OAPP Service Utilization Data N=19,149	OAPP Service Utilization Data Frequency
Services	**%**	**%**	**%**	**# of Units**
Outpatient Medical Care	68.3	--	62.7	9.2
Case Management	55.3	44.1	26.2	6.7
Food Pantry	48.8	--	19.0	5.6
Dental Care	48.8	--	9.1	5.7
HERR	44.7	21.8	5.2	2.0
Peer Counseling	42.0	--	11.9	6.3
Outpatient Mental Health Services	41.5	27.2	18.6	9.8
Housing Information Services	30.9	19.6	7.8	9.2
Van Transportation	24.8	39.2	10.8	3.8
Emergency Financial Assistance	18.3	--	2.1	6.3
Outpatient Substance Counseling	16.7	--	2.2	65.2
Home Health Care	11.8	7.9	1.5	68.8
Hospice	5.7	--	2.2	134.9
Day Care	2.8	1.1	1.3	28.1

Service Gaps

In addition to the ranking of service needs, two gap measures were calculated for the needs assessment.

- First, the difference between what services are needed and what services are asked for ("unmet need") indicates a gap between what PLWH/A believe they need and their expectation of receiving a service. PLWH/A may not ask because they know or perceive that they are ineligible, feel that they have no access, or do not know who to ask for in order to obtain the service. These barriers are explored later in the report.
- Second, the difference between what is asked for and what is received, "unmet demand", the misperception of the consumer about their eligibility for a service and/or the system's lack of capacity to provide requested services. Organizational barriers are further explored in the following section.

Figure 1-34 displays unmet demand and unmet need for 20 services, ranked by the unmet demand. It includes services ranked high by the commission plus two additional service categories where there was a greater than 5% gap in either unmet demand or unmet need (legal services and peer counseling).

Figure 1-34 indicates that:

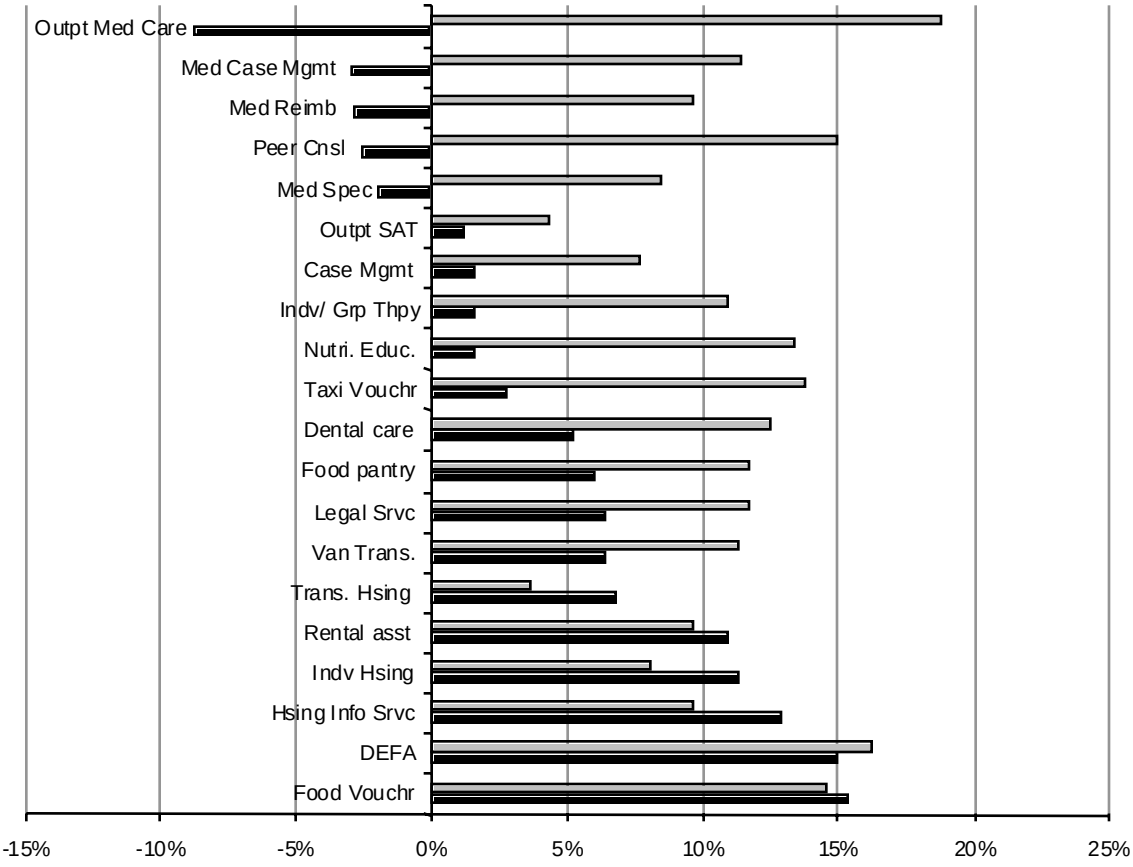
- The overall message is that unmet need is rather high with more than a third of the services being 10% or more. Services with a large unmet need (expressed need minus reported demand) are outpatient medical care (19%), emergency financial assistance (16%) and peer counseling (15%).
- Unmet demand is very small for services within the primary health care core but not for the area of housing and financial assistance (for rent, food and emergencies).
- In contrast to unmet need, outpatient medical care shows the largest negative unmet demand which reflects that people receiving the service more than they ask for it. The likely explanation is most PLWH/A don't ask for the service; rather appointments are routinely scheduled. That would mean that more people receive services than "ask" for them. There is, however, an unmet need with nearly 20% of PLWH/A saying they need it, but do not ask for it. This could reflect the unmet demand explanation with PLWH/A knowing that they need to maintain their medial care but not necessarily needing to ask for it considering appointments are regularly scheduled. This explanation is most valid considering there were only about 2% of the sample who had not seen a doctor before May 2001–or about 6 months before the survey, notably 11% of the sample gave no date, and some of these may also not be seeing a doctor. Other reasons for not asking for medical care may be connected to good health or barriers to the service which are discussed later in consumer forum comments later in this report.
- The service with the greatest unmet demand is food vouchers. Fifteen percent (15%) of PLWH/A ask for but did not receive food vouchers. This service also has the fourth highest unmet need (15%). Discussions within the consumer forums expressed the absence if not

shortage, of vouchers. Interviewed PLWH/A prefer food vouchers over food pantry as a means of contributing to a independent lifestyle.

- Direct Emergency Financial Assistance (DEFA) to pay for rent, utilities, and food is the highest unmet need and the second highest unmet demand. Many PLWH/A are probably not aware the service exists and is currently funded by HOPWA in Los Angeles County.
- Housing is a service category with a large unmet demand with four of the five subservices surpassing a 5% unmet demand. Thirteen percent (13%) asked for housing information services but did not receive it. Similarly, 11% asked for independent housing and for rental subsidies. Seven percent (7%) of the sample have asked for emergency or transitional housing in the last year and have not received it. This suggests that housing is high on the agenda of PLWH/A and they ask for it when they perceive they need it. As is clear by the survey and focus group responses, however, the demand for quality housing far exceeds the systems capacity to provide it.
- Three other services have a demand gap above five percent: van transportation (7%), legal services (7%) and food pantry (6%).
- With the exception of the nine services mentioned above, when PLWH/A ask for services they report receiving it. Important to note is that , with the exception of dental care, the nine services with a high unmet demand are not categorized under the continuum of care's primary health care core.
- Peer counseling is the service with the third highest unmet need (15%). As the HIV/AIDS community becomes more diverse, so does the need for specialized groups for various populations. Two group ideas brought up within the many consumer groups included one for monolingual Latino males and one for long-time survivors.
- Dental care is the seventh highest in unmet need. This may reflect the realization of many PLWH/A that services do not cover some dental needs. It may also reflect difficulty in obtaining appointments, traveling to available dental services, and also difficulty finding a dentist that accepts their insurance.
- Other services with a difference of more than 10% between needing and asking for the service include: nutritional education, food pantry, legal, medical case management, van transportation, and individual/group mental health therapy.
- Not shown on the graph, about 5% more PLWH/A reported receiving HERR. However, expressed need was greater than demand, suggesting that not everyone who needs it is asking for it, but once they ask for it, they receive it.

To better understand these gaps, the next section discusses general barriers to the system. The conclusion of this report will also pull these findings together and suggests some possible actions to overcome these gaps.

Figure 1-34 Service Gaps



	Food Vouchr	DEFA	Hsing Info Srvc	Indv Hsing	Rental asst	Trans. Hsing	Van Trans.	Legal Srvc	Food pantry	Dental care	Taxi Vouchr	Nutri. Educ.	Indv/ Grp Thpy	Case Mgmt	Outpt SAT	Med Spec	Peer Cnsl	Med Reimb	Med Case Mgmt	Outpt Med Care
Need - Ask	14.6%	16.3%	9.8%	8.1%	9.8%	3.7%	11.4%	11.8%	11.8%	12.6%	13.8%	13.4%	11.0%	7.7%	4.5%	8.5%	15.0%	9.8%	11.5%	18.9%
Asked - Rec	15.4%	15.0%	13.0%	11.4%	11.0%	6.9%	6.5%	6.5%	6.1%	5.3%	2.8%	1.6%	1.6%	1.6%	1.2%	-2.0%	-2.6%	-2.8%	-3.0%	-8.7%

BARRIERS

The PLWH/A participating in the survey were asked about barriers to services in question 39 of the survey (see Attachment 1). They were asked to rank 30 different potential problems on a scale ranging from "not a problem" to a "very big problem." These barriers were not "linked" to a particular service category. As shown in Table 1-9, the thirty potential problems can be classified into the more general categories of "organizational", "structural", or "individual" barriers.

- Structural barriers refer to "rules and regulations" and levels of access. Rules and regulations include insurance coverage, cost of services, bueracratic challenges ("red tape"), eligibility and problems navigating the system of care. On average, about 60% of the PLWH/A are likely to have a problem with these types of barriers. Structural "access" barriers have to do with lack of transportation, access to specialists or lack of family-oriented services. These are mentioned less frequently than "rules and regulations" but still about 45% of PLWH/A registered they had a problem with these types of barriers.
- Organizational barriers refer to provider sensitivity and provider expertise. Sensitivity barriers include the provider's response to the PLWH/A's issues and concerns, making the client feel like a number, rather than an individual, and helpfulness of the provider. On average, nearly 55% of the sample reported experiencing this type of barrier. Provider expertise includes the perceived experience of providers, ability to provide correct referrals and ability of providers to get along with clients. On average, nearly 60% of PLWH/A note that they have experienced these types of barriers.
- Individual barriers refer to the individual's knowledge, well-being, ability to communicate with the provider and possible denial of their serostatus. Like "rules and regulation" barriers, about 60% of the PLWH/A mention knowledge and well-being barriers.

Table 1-9 Types of Barriers

1=Very small, 2=Small, 3=Moderate, 4=Big, 5=Very big **STRUCTURAL**	% WITH PROBLEM	% WITH BIG PROBLEM	AVERAGE BARRIER SCORE
Rules and Regulations			
1. The amount of time I had to wait to get an appointment or to see someone.	67.5%	33.1%	3.0
2. My ability to find my way through the system.	62.2%	29.0%	2.8
3. There was too much paperwork or red tape.	61.4%	37.7%	2.9
4. My lack of, or inadequate, insurance coverage.	57.7%	37.7%	2.9
5. I was not eligible for the service.	56.9%	38.5%	2.9
6. There are too many rules and regulations.	56.5%	33.6%	2.9
7. I can't afford one or more of the services.	53.3%	38.0%	2.9
Access			
8. No transportation.	58.9%	45.7%	3.2
9. There was no specialist to provide the care I needed.	52.4%	20.8%	2.5
10. I have been denied or have been afraid to seek services due to a criminal justice matter	40.2%	25.0%	2.4
11. No childcare.	37.0%	40.3%	2.9
12. I have been terminated or suspended from seeking services.	36.2%	27.1%	2.5
ORGANIZATIONAL			
Provider Sensitivity			
13. Sensitivity of the organization and person providing services to me regarding my issues and concerns.	64.2%	34.6%	2.9
14. The organization providing the service made me feel like a number.	61.8%	36.5%	3.0
15. Discrimination I experienced by the persons or organization providing the services.	56.5%	28.1%	2.6
16. The people providing services to me are not helpful.	53.7%	20.4%	2.4
17. Fear of my HIV or AIDS status being found out by others – lack of confidentiality.	52.0%	41.6%	3.1
18. Fear that I would be reported to immigration or other authorities.	30.5%	14.9%	2.2
Provider Expertise			
19. Experience or expertise of the person providing services to me.	63.8%	32.3%	2.9
20. The organization did not provide the right referrals to the services I needed.	56.9%	22.9%	2.5
21. I do not get along with the people providing services.	50.0%	16.3%	2.3
INDIVIDUAL			
Knowledge			
22. Not knowing that service or treatment was available to me	72.4%	40.0%	3.2
23. Not knowing location of the services.	66.7%	30.4%	2.9
24. Not knowing who to ask for help.	64.6%	36.8%	2.9
25. Not knowing what medical services I need to treat my HIV infection or AIDS.	59.8%	34.2%	2.8
26. Not understanding instructions for obtaining service or treatment	57.7%	22.1%	2.6
27. My ability to communicate or interact with the service provider.	48.0%	16.9%	2.3
Well-Being			
28. My physical health has not allowed me to get to the place where the service is provided	60.2%	28.6%	2.6
29. My state of mind or mental ability to deal with treatment.	64.6%	29.5%	2.8
30. I not believe HIV/AIDS is a problem for me that requires assistance (denial)	67.5%	34.1%	2.9

Figure 1-35 graphs the three types of barriers. It shows that, in general people may rate barriers to be a moderate to small but at least 50% of the participants have considered the barrier a problem to getting the service. More insight into which services clients experience these barriers with will be given in the form of comments from the consumer forums excerpted later in this report. The graphics show:

- Among the 'rules and regulations' structural barriers, over 50% think that there are structural problems that prevent or inhibit them from getting a service but they rate the problems to be

moderate. The largest problem appears to be the amount of time it takes to get an appointment followed by: navigating through the care system, red tape, lack of or inadequate insurance coverage, being ineligible for the service, rules and regulations and cost of the service. While these do not appear to stop most PLWH/A from receiving care once they ask for it, they may, as noted in the data, stop persons who are eligible from asking for services.

- Among the 'access' structural barriers, not having transportation to the service was the largest problem to accessing the service (59%). Fifty-two percent (52%) felt the lack of a specialist available to provide the care needed was a problem and this barrier was particularly largely in SPA 5 (65%), notably the only SPA without Title I-funded medical provider (although Venice Family Clinic, funded by Title III, is located in the SPA). Not having childcare was experienced by 37% of the sampled population which closely relates to the 39% of the sample that have at least one child at home.
- Among 'provider sensitivity' organizational barriers, 64% felt the lack of sensitivity of the organization was a problem they experienced. In the consumer forums, PLWH/A expressed also feeling like a number by their providers (62%). The fear of authorities as a problem (31%) is most probably experienced by the nearly 30% PLWH/A sample born outside the U.S. and also amongst the recently incarcerated. In the consumer forums, women with children at home brought up the concern of their children being taken away from them because of providers' perception of their inability to care for them.
- Among 'provider expertise' organizational barriers, 64% say the lack of experience or expertise of the person providing services can be a problem. Based on feedback from consumers, this is mostly experienced due to high staff turnover over in case management programs.
- Among 'knowledge' individual barriers, 72% say they have had a problem in not knowing that a service or treatment was available to them. The lack of knowledge about services represents the highest barrier for PLWH/A. PLWH/A express this lack of knowledge as a function of misinformation or incomplete information offered to them by providers. Sixty-five percent (65%) also feel that not knowing who to ask for the service is a problem particularly for non-CARE Act-funded services. The 48% of the PLWH/A that report an inability to communicate or interact with the service provider is probably experienced by monolingual Latinos and those with a low education or reading level.
- The 'well-being' individual barriers are particularly high considering participants are reflecting on themselves with these responses. Surprisingly, nearly 70% of the sample confess to allowing denial of their serostatus to prevent them from getting services. This would most probably be connected to medical care. The state of mind of the PLWH/A has also prevented them from getting services (65%).

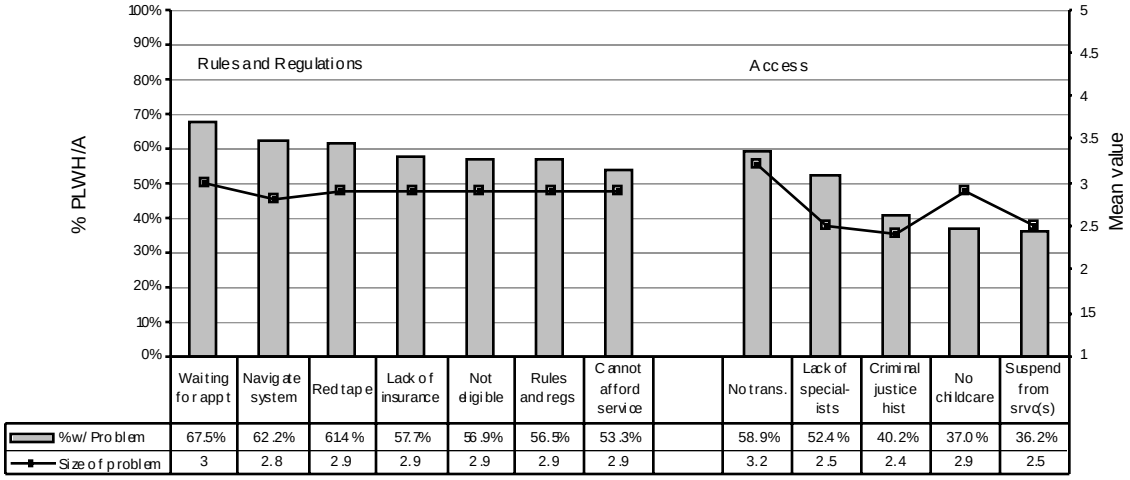
For more information across the different populations, please refer to Attachment 10 and Attachment 11. Following are consumer forum comments, organized by barrier category, expressed about general barriers in getting services.

In the ongoing analysis of this data, the strength of the relationship between the height of the barrier and the likelihood of receiving services will be reported.

Figure 1-35 Barriers to Services

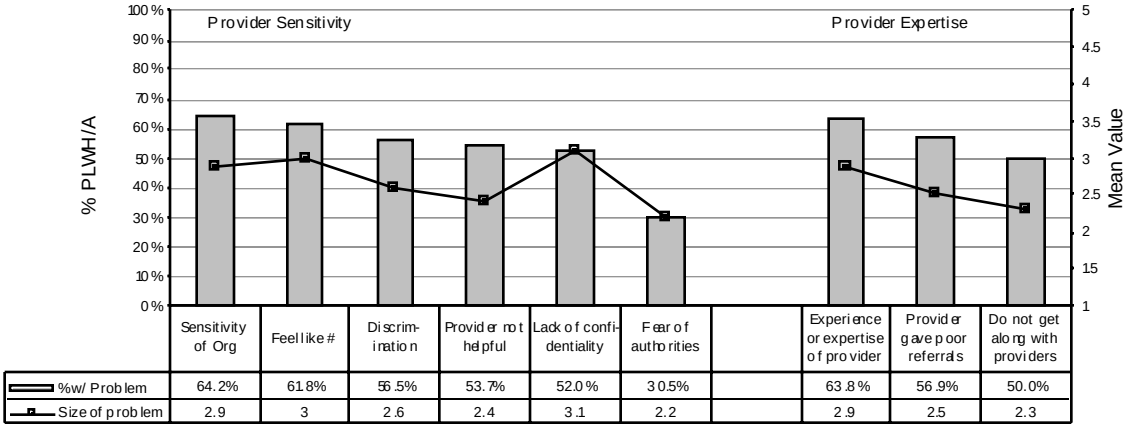
1=Very small, 2=Small, 3=Moderate, 4=Big, 5=Very big

Structural



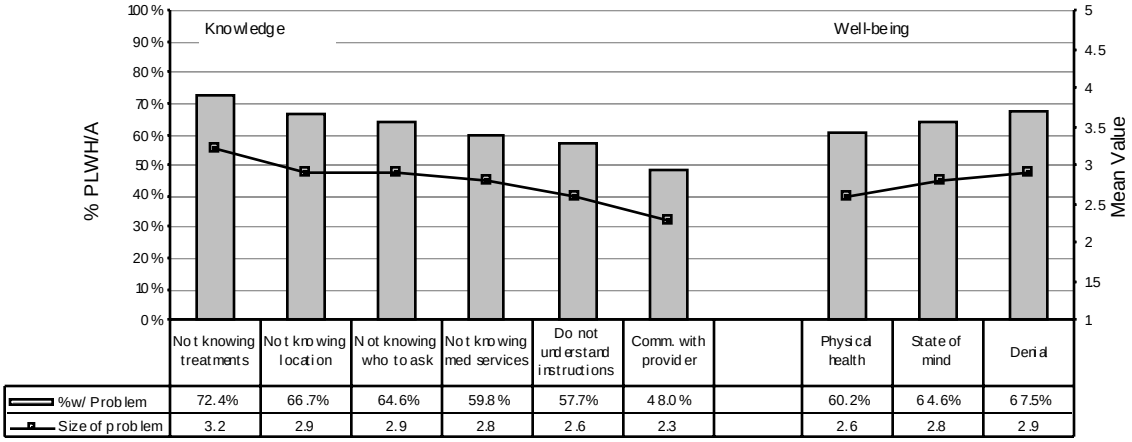
	Waiting for appt	Navigate system	Red tape	Lack of insurance	Not eligible	Rules and regs	Cannot afford service		No trans.	Lack of special-ists	Criminal justice hist	No childcare	Suspend from srvc(s)
%w/ Problem	67.5%	62.2%	61.4%	57.7%	56.9%	56.5%	53.3%		58.9%	52.4%	40.2%	37.0%	36.2%
Size of problem	3	2.8	2.9	2.9	2.9	2.9	2.9		3.2	2.5	2.4	2.9	2.5

Organizational



	Sensitivity of Org	Feel like #	Discrim-ination	Provider not helpful	Lack of confi-dentiality	Fear of authorities		Experience or expertise of provider	Provider gave poor referrals	Do not get along with providers
%w/ Problem	64.2%	61.8%	56.5%	53.7%	52.0%	30.5%		63.8%	56.9%	50.0%
Size of problem	2.9	3	2.6	2.4	3.1	2.2		2.9	2.5	2.3

Individual



	Not knowing treatments	Not knowing location	Not knowing who to ask	Not knowing med services	Do not understand instructions	Comm. with provider		Physical health	State of mind	Denial
%w/ Problem	72.4%	66.7%	64.6%	59.8%	57.7%	48.0%		60.2%	64.6%	67.5%
Size of problem	3.2	2.9	2.9	2.8	2.6	2.3		2.6	2.8	2.9

Structural

Rules and Regulations

Hours of operation of agency or service provider
A SPA 4 Anglo MSM said, *"The hours certain services are available is very limiting. This evokes an attitude of 'We'll help you when it is convenient for us to do so, but good luck - you're on your own when we're not available.' When hours are posted 'Open until 5', please don't stop answering phones and don't lock doors at 4:45pm."*

Lack of coordination of services
A SPA 4 Asian MSM said, *"There must be a need for more easier connections with other agencies."*

My ability to find my way through the system
A SPA 4 API heterosexual male said, *"I'm very confused with the procedure to get the service, because I have been referred to many organizations. Sometimes I don't know where to initiate the service or where to start the procedure."*

A SPA 7 Latino MSM said, *"There are a lot of obstacles and a lot of requisites in order to receive some of the services. I think that being HIV-positive is enough requisite to get help."*

There was too much paperwork or red tape
A SPA 4 Anglo MSM said, *"Very often printed information provided is not legible or is in extremely tiny print. Sometimes copies of forms are too light to be read or not properly centered. These are often forms that need to be submitted to employers or doctors for completion. It makes it look bad for the applicant to submit such sloppily composed documents."*

A SPA 7 Latina said, *"My experience is that if you plan to switch to another clinic or case manager they take, once again, all the information from your heart and your brain and make you feel worse than a cockroach."*

I do not get along with people providing services
A SPA 1 Anglo IDU female said, *"Overall I'm very please with my clinic. My biggest issues are with governmental programs that want you to get off welfare and then punish you for doing better, so you don't need it anymore. I cannot get insurance coverage. That is or has been the most frustrating thing for me. I have been HIV-positive for 19 years. I don't have problems accessing services. My main problem is not having any symptoms so I don't qualify for SSI."*

A SPA 6 heterosexual female said, *"The government doesn't see HIV as a disability. The government just sees HIV which makes it hard to get SSI. I became HIV positive in 1993 and I was trying to get government funding for the longest. When I went on my fifth trip to the hospital with pneumonia, my T-cells dropped so low and they said, 'Okay, you are in the category of AIDS now.' So when they say AIDS, that's when the government says, 'Well, this person has*

AIDS. They are gonna die soon.' So then the government comes right in and boom - you get a check within two weeks. But as long as you're HIV-positive, it's not a disability to the government. It's not right. It's not fair but that's the way the government system is set up."

I was not eligible for the service

A SPA 7 Latino MSM said, *"The people that do not have documentation do not qualify for services. Ninety percent of us who come to this clinic do not have documents. And the services that the government gave us has come to an end. What we can do is go to [the Latino focused ASO], but they do not help us there."*

A SPA 7 Latino MSM said, *"I can speak for my partner because he doesn't have any papers. He is not receiving any kind of help. I'm trying to help him with SSI. When you are infected with HIV you get SSI. I'm trying to find some help for him because I'm the one who is receiving everything."*

My lack of, or inadequate, insurance coverage.

A SPA 3 African American MSM said, *"My main concern is to get adequate knowledge of insurance and medical coverage now and in the future."*

A SPA 3 male said, *"I'm not entitled to MediCal anymore. I'm not entitled to get MediCal, because of where my health status is at. In order for me to get MediCal I have to have a diagnosis of AIDS. Why do I have to wait to get sick to get something?"*

A SPA 4 Latino transgender said, *"I have emergency MediCal. That only covers when you get sick. You can go to the clinic and get help. But other than you don't get any service nor do you get any benefits with MediCal. And some of my medications aren't covered with MediCal. I have a problem because I have to search for a way to get my medication covered."*

A SPA 4 Anglo MSM said, *"I've had difficulty getting high quality medical care with an HMO. In years past when I had private insurance, I got very high-level personalized care, but paid a good amount out of pocket. With current HMO through work, I pay much less out of pocket but get lower level, less personalized care. Currently I receive acceptable care at [at the HMO clinic], but earlier in the year I received completely superior care at [a private clinic]."*

A SPA 7 Latino MSM said, *"I applied for MediCal, but I did not qualify, so I was denied. It was denied because I don't have any papers. I became ill and it was in the hospital that a nurse helped me obtain emergency insurance."*

A SPA 8 male said, *"My main concern is the Medicare/MediCal system needs to be made easier. Make it all-inclusive. There are some that are sicker than others but make it all-inclusive. Include everybody that needs medical care."*

Access

Transportation
A SPA 1 African American heterosexual female said, *"We need more adequate services and accessibility here in the Antelope Valley."*

A SPA 7 female said, *"Some things that keep me from seeing the doctor is the traveling to the site. Sometimes I'm not feeling good or tired. It's just the traveling and I have no assistance with transportation other than the bus."*

Organizational

Provider Sensitivity

Sensitivity of organization to my issues
A SPA 6 male said, *"The looks from the providers can be very emotionally disturbing. Basically what it really boils down to is the service isn't given in a caring way."*

Treated Like a Number
A SPA 3 Anglo IDU male said, *"I believe patient advocates are a must. There is too much bickering. I am a person, not a dollar sign."*

A SPA4 Anglo MSM said, *"It would be nice to be treated like a person, instead of being treated like a number."*

A SPA 4 Anglo MSM said, *"The smaller the facility and the smaller the clientele means better service. They can treat you like a number at the larger agencies. I go to [an ASO] in the valley which is much more people friendly than the [same ASO] in LA. I give a lot of people rides so I see how they are treated in the different settings."*

Quality of Service
A SPA 4 Anglo IDU male said, *"I feel very lucky the people care enough to help me, however services could improve."*

Fear of my HIV/AIDS status being found out by others – lack of confidentiality
A SPA 5 Anglo IDU said, *"I've found that there is a huge problem with confidentiality with a lot of the services offered."*

Discrimination I experienced by the persons or organization providing the service
A SPA 4 Asian MSM said, *"I believe that an open and a just service should be open to those who are not USA citizens and to those who don't have green cards."*

A SPA 4 Latina transgender said, *"There is a lot of discrimination in my community because we're transgender. They believe we're not honest women and also think we use drugs. A lot of the managers do not help us because of our sexual condition."*

A SPA 8 African American MSM said, *"I have been discriminated against due to my healthy physical appearance. Agencies overlook my past of undocumented opportunistic infections (pneumonia, shingles, thrush, etc). I also have emotional and mental conditions, as well as internal medical problems which are not "skin surfaced" yet. Many people with HIV who are not as ill or who have not lived with AIDS are given more services due to an outward 'AIDS look', totally overlooking individuals like myself who came onto the 'scene' full blown with AIDS with only 112 T-cells and who have maintained but are still struggling with the disease. It's unfair and extremely discriminatory. I pray that one day each individual is given assistance as needed on a case-by-case, and individual by individual basis."*

Fear of being reported to authorities

Within a SPA 7 community forum, a female said, *"I feel sometimes that if I get sick that they will come and take my son from me. Sometimes I don't feel good and then sometimes they call me, my social worker, and they say, 'How do you feel?' I'll say I feel good and that I'm okay but I don't feel good. I'm scared because of my children."* Another female followed by saying, *"When I was dealing with that agency, I wouldn't dare call them and let them know that I was feeling bad or didn't have food."* And another added, *"Yeah, because it's like you don't even have to have an open case. If you are asking for a food voucher or trying to get connected with the pantry, they just automatically assume that you are not able to take care of your kid."*

A SPA 7 female said, *"My problem was that I had a daughter that had AIDS and she died five years ago. Two weeks after she died I got a call from my kid's doctor's clinic from the case manager stating that if I didn't have my son into his doctor's office for his appointment then they were going to come and take my son away from me. This was two weeks after I buried my daughter in the ground. I stopped going to that clinic two weeks previous of my daughter dying. My daughter died at home with her family and I called the doctor and I said, 'I'm not bringing my son into your clinic anymore.' I never said he wasn't going to see a doctor. I just said he wasn't going to see that doctor because I had it up to here with arguing and fighting with the doctors. I wasn't going to do it."*

Provider Expertise

Experience or expertise of the person providing services to me

A SPA 7 Latino MSM said, *"I'm not satisfied most of the time. After I ask for all the different types of information, they dismiss you for any type of mistake that they themselves have committed. My food coupons were just cut off, but I don't want to go there and ask for them because you waste too much time. There are a lot of problems with [the Latino focused ASO] service."*

I do not get along with people providing services

A SPA 4 Anglo MSM said, *"A lot of providers give the attitude of a relaxed setting. They act like 'We'll get around to you when we get around to you.' People don't seem to be working and ignore people who need the assistance. It's not everybody, but it's enough that it's aggravating. So I've seen it enough that I've said 'To hell with that, I don't have to be around this.'"*

Individual

Knowledge

The HIV/AIDS services I need are not (always) available
A SPA 1 African American male said, *"More adequate facilities in the Antelope Valley are needed and greater accessibility and more resources."*

A SPA 3 male said, *"There's not enough services. The money goes only to certain areas because of the (epidemiological) numbers. There are people that are not getting the services that they're getting because of the numbers that are needed right here. Because (certain neighborhoods) have more money, they can give more services or better adequate services than what we're getting out here. Because they're getting a bigger grant than what we're getting. But it seems like the budding thing is out here because of the Hispanic and African American communities and the females are the ones that are suffering the most now. See, if they don't step forward, or they don't know, then there's no money. There's not enough money out here. There's not enough money. They can't hire the proper people at the facilities that we need. That's why there's a case manager that has over 120 on her case load."*

A SPA 8 male said that there is a misperception about the allocation of funding, *"The South Bay has always been kind of the forgotten corner of LA. I should have brought you the newspaper article showing the County funding. We have 18% of the HIV/AIDS cases known in LA County out here in South Bay yet we are only getting like 8% of the funding. They group South Bay in the same spot as Long Beach. They cut the check to Long Beach and they are supposed to share with us but they don't and we're stuck with nothing. It's been going on for years."* In fact, SPA 8 has about 16% of PLWH/A, but reports about 10% of clients seen by all CARE Act-funded providers. They receive about 10% of the CARE Act funding.

A SPA 8 male said, *"It's a big problem. There is not enough money available to us and then the criteria to get the money that's there. I understand that there is a priority list and I appreciate that. We need some money. We need some more money in the system, a bigger bank."*

A SPA 6 African American heterosexual female said, *"Since I was diagnosed with HIV (six months ago), the services provided to me have been beneficial. Only because I'm newly diagnosed, my biggest fear is not getting all the services needed like legal, housing, employment or financial means."*

A SPA 6 male said, *"In the two year period I've been diagnosed, I've been to three different agencies for three different matters and I have found that here at [the local ASO] a lot of services are not here. We are referred to other agencies to fulfill whatever needs we need fulfilled that are not here. I've gone over to [another ASO] for different matters as far as nutrition is concerned to see a dietician, a licensed dietician. We do not have a licensed dietician here. We do not have a nutrition program here."*

A SPA 6 male said, *"I was referred to [CARE-funded provider] when I was newly diagnosed and of course I was told, 'You're not in our jurisdiction.' I worked a block away from [provider] and had been doing some services and benefits for [provider] and I guess it was a warped sense of thinking that, 'Oh well they'll be there when I need them since I've done all of this,' and then when I did eventually have to access them they sent me somewhere else. I wasn't familiar with [another agency], but yet when I got here I noticed that of course as far as the service support is not as strong as it may be in other parts of the city and that's all I wanted to reiterate, because it's not. It just seems like there are not enough funds here to actually benefit the people that have been infected for some time and let's face it for others that may be coming after us. It's just the funding in the area for this particular agency is not as strong as others."*

<u>*Not knowing what services exist for treating my HIV infection*</u>
A SPA 4 Latina transgender said, *"They don't give us information about what services I can have after I get an AIDS diagnosis. We don't know anything about those services."*

A SPA 4 Latino MSM said, *"Seeing us growing from the mid-'80's until now, a lot of changes have happened to us, with medication and the reduction of our need for services. Therefore, there are less of us coming here to get services and then the agencies don't get enough money to do it. My opinion is I would like to see a central place be more active with people who don't know about services by providing a central place where everybody has access to what is available rather than going individually. I don't like to hear from another client that there is a place that I could have gone for services I needed. It was always there, but even though I am in the community and I do service I don't hear this. I would like to see a central place available for information."* In fact, the number of clients accessing the service system, the number of service units delivered, and the amount of CARE Act and other government funding for HIV/AIDS services have steadily increased since the late 80s.

A SPA 4 Anglo MSM/IDU added, *"In Phoenix, when I was newly diagnosed, they had a service for when you were newly diagnosed. They would go to your house and do an intake with you and bring all the paperwork from all the different agencies in the area that you lived in and they told you what things would help you out. When I moved here to LA within the last year, I had no idea who to go see, where to go, what's offered to me. I still don't know a lot of what's offered to me out here. My case manager out here did a small amount of that on a small scale. The only food bank I know of is this one through [this agency] and I think it's because my case manager is here. They're going to try to get you to do everything that is [at this agency]."*

A SPA 4 IDU male said, *"I found that most of the things I know now, which I consider to be fairly vast in comparison to the Average Joe coming in here, was very difficult to find out. I'm sure that there are a lot of things that I don't know. There are some services on this list that I do know about and some that I don't think I do because I haven't experienced it. I don't think that they make this information available."*

A SPA 6 African American heterosexual female said, *"Having been placed in a nursing home by my children when diagnosed with AIDS (July 2000), I did not receive any information regarding HIV/AIDS services such as case management, transportation, food bank, housing, etc. This*

created a great deal of stress when I was released six months later. It also caused considerable financial hardship. There should be HIV/AIDS information classes offered to all facilities."

My ability to communicate or interact with the service provider
A SPA 7 Latina said, *"The doctors do not even speak Spanish. That's one of our big needs. The psychologist and the social worker don't speak Spanish. Nobody speaks Spanish. And you know what they tell you? 'Go to school and learn English.'"*

A SPA 7 Latino MSM said, *"I think there should be a lot more agencies with Spanish services. I think that it is really important, for one that is ill, to receive attention in Spanish."*

Well-Being

My state of mind or mental ability to deal with the treatment
A SPA 5 Anglo IDU female said, *"I just wanted to say I used to like meth and I did do it while getting treatment. But I found that it made me more sick and it messed with my memory. I had a hard time remembering things so I eventually stopped and have just maintained it. I'm pregnant so I have to keep it up, but I did enjoy it. The downside of it was memory. It's like I would go backwards. I'd be taking my medicine and I would go forward and every time I messed up and played around with it recreationally it just set me back so far."*

Barriers to Individual Services

The above barriers were reported for the overall care system. In the focus forums, however, participants were probed for barriers to specific services. The following are barriers to services mentioned by participants in the 29 consumer forums. They are presented in order of the priorities in the recommended Continuum of Care. While they cannot be quantified, they do indicate they are barriers for at least some PLWH/A. Extracted quotes from those forums can be read in the Los Angeles Consumer Forum Report.

Primary Health Care Core

Outpatient Medical Care:

1) The HIV/AIDS services I need are not (always) available, particularly among transgender individuals living with HIV or AIDS who wanted a transgender sensitive physician.
2) No childcare.
3) My ability to communicate or interact with the service provider.
4) Not being able to get options about treatments from the people I go to for services
5) I do not believe HIV is really a problem for me that requires assistance.
6) Experience or expertise of the person providing services to me.
7) My state of mind or mental ability to deal with the treatment.
8) The quality of service.
9) No transportation.
10) My lack of, or inadequate, insurance coverage.
11) The amount of time I had to wait to get an appointment or see someone.

Dental Care

1) The HIV/AIDS services I need are not (always) available.
2) The cost of the service to me.
3) The discrimination I experienced from people providing services to me.
4) The quality of service.
5) No transportation.
6) The amount of time I had to wait to get an appointment or see someone.

Nutritional Education and Counseling

1) The HIV/AIDS services I need are not (always) available.

Mental Health

1) My ability to communicate or interact with the service provider.
2) Experience or expertise of the person providing services to me.
3) My lack of, or inadequate, insurance coverage.

Medication Reimbursement

1) There was too much paperwork or red tape.
2) My lack of, or inadequate, insurance coverage.

Medical Care with a Specialist

1) My lack of, or inadequate, insurance coverage – uninsured
2) The amount of time I had to wait to get an appointment or see someone – wait

Medical Case Management

(no barriers mentioned)

HERR

(no barriers mentioned)

Substance Abuse Treatment and Counseling (outpatient, residential and detox)

1) Too many rules and regulations to get the service.
2) Not knowing that the service or treatment was available to me.
3) The amount of time I had to wait to get an appointment or see someone.

Home Health Care

1) The HIV/AIDS services I need are not (always) available.
2) Too many rules and regulations to get the service.

Complementary Health Care

(no barriers mentioned thus far)

Removal of Barriers

Food Pantry
1) The discrimination I experienced from people providing services to me.
2) The quality of service.
3) Too many rules and regulations to get the service.
4) No transportation.

Taxi Voucher
1) The HIV/AIDS services I need are not (always) available.
2) Not knowing what services exist for treating my infection.

Independent Housing
1) The HIV/AIDS services I need are not (always) available.
2) The discrimination I experienced from people providing services to me.
3) I was not eligible for the service.
5) The quality of service.
4) Too many rules and regulations to get the service.
3) The amount of time I had to wait to get an appointment or see someone.

Transitional Housing
1) The HIV/AIDS services I need are not (always) available.
2) Too many rules and regulations to get the service.
3) The lack of sensitivity of the service provider to my issues and concerns.

Home-Delivered Meals
1) Fear of my HIV/AIDS status being found out by others.
2) Not knowing which organization to go to for the service.

Food Vouchers
1) The HIV/AIDS services I need are not (always) available.
2) The discrimination I experienced from people providing services to me.

Rental Assistance
(no barriers mentioned)

DEFA
1) The HIV/AIDS services I need are not (always) available.
2) The discrimination I experienced from people providing services to me.
3) Not knowing what services exist for treating my infection.
4) There was too much paperwork or red tape.

Van Transportation
1) The HIV/AIDS services I need are not (always) available.
2) I was not eligible for the service.

Day Care
1) The HIV/AIDS services I need are not (always) available.

Patient Care Coordination

Case Management
1) The HIV/AIDS services I need are not (always) available.
2) Lack of coordination of services.
3) I was not eligible for the service.
4) Experience or expertise of the person providing services to me.
5) The people providing services to me are not helpful.
6) Not knowing what services exist for treating my HIV infection.
7) The organizations providing the service making me feel like a number.
8) The organization did not provide the right referrals to the services I need.

Housing Information Services
1) The HIV/AIDS services I need are not (always) available.
2) The people providing services to me are not helpful.
3) Not knowing which organization to go to for the service.
4) The quality of service.
5) The organization did not provide the right referrals to the services I need.

Economic Well-Being Measures

Legal Services
1) The cost of the service to me.
2) The people providing services to me are not helpful.
3) There was too much paperwork or red tape.

Vocational Assistance
(no barriers mentioned)

Health Insurance Assistance
(no barriers mentioned)

Enhancement Service Options

Peer Counseling
1) The HIV/AIDS services I need are not (always) available.
2) I do not believe HIV is really a problem for me that requires assistance.
3) The people providing services to me are not helpful.
4) Hours of operation of agency or service provider.
5) No transportation.

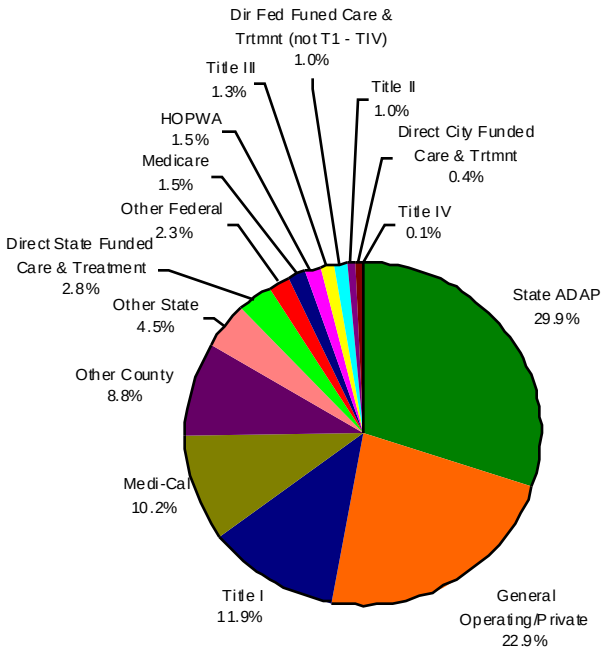
AVAILABLE FUNDING AND SERVICE ALLOCATION[5]

The information presented below was derived from contract information and reports, and OAPP. It should be considered an estimate and conditional until findings of the financial needs assessment can be incorporated into an updated Plan.

All Funding for the Continuum of Care

Overall, as shown in Figure 1-36, there was over $261 million in funding for care services in 2001. State ADAP contributes 30% to the overall funding, making medication reimbursement the service with the greatest funding in the continuum of care. The second largest funding category, providing 23% of the total funding, is private and general operating funds from providers. This is a rough estimate based on reports from providers (Attachment B), and is used to fund many different service categories in the continuum of care. Third, at 12% of the total funding, is CARE Act Title I funds. The allocations to services are discussed in greater detail below. MediCal (10%), "other county" funds (9%), and other State funding (4.5%) are the next largest sources of funding in the continuum of care. Although housing is a large stated need by PLWH/A, overall, HOPWA contributes about 1.5% of the overall funding. Actual dollar amounts are shown in
Table 1-10.

Figure 1-36 Funds Being Utilized for HIV/AIDS Services 2001 - % Contribution
Based on $261,543,363 (which are not all the funds available in the system)



[5] The Commission contracted a financial needs assessment, but due to contract delays, it was not completed at the time this Plan was written. When the information about the sources and service allocations of non-Ryan White funding becomes available and can be combined with the Ryan White service allocations this section of the report will be updated.

Table 1-10 Sources of Funding 2001 - $ Contribution

State ADAP	$78,141,084
General Operating/Private	$59,786,342
Title I	$31,241,061
MediCal	$26,618,203
Other County	$22,976,717
Other State	$11,746,175
Direct State Funded	$7,449,924
Other Federal	$5,966,831
Medicare	$3,836,071
HOPWA	$3,815,363
Title III	$3,502,777
Direct Fed Funded (not RWTI & II)	$2,595,444
Title II	$2,507,824
Direct City Funded	$1,115,914
Title IV	$243,633
TOTAL	$261,543,363

Distribution of Ryan White Title I and II Funds

The distribution of funds for 2003, based on the Continuum of Care, is shown in Table 1-11. The Continuum was modified slightly in 2002, as noted previously, where the Commission has made Removal of Barriers the second priority, and Patient Coordination and Language Care services the third priority. Within the five groups of services, the Commission moved medical case management from Removal of Barriers to Patient Care Coordination.

Between 2002 and 2003 the recommended allocations have remained nearly the same. Small increases in transportation, dental, food and peer support, and the establishment of client advocacy reflect those services in great demand or where service gaps are reported. There is also slightly more case management as providers begin to adopt specific programs of case management with nurse case managers or nurse practitioners in medical settings.

Table 1-11 RW Title I & II 2002 and Recommended 2003 Allocations

PRIORITY	SERVICE CATEORIES	2003 % srvcs TI & TII
#1	**Primary Health Care Core**	**64.4%**
high	Ambulatory/outpatient medical services, early intervention	0.0%
high	Ambulatory/outpatient medical services, preventive care and screening	0.0%
high	Ambulatory/outpatient medical services, patient education	0.0%
high	Ambulatory/outpatient medical services, medical	42.4%
high	Ambulatory/outpatient medical services, specialty	1.1%
high	Drug reimbursement, State ADAP	0.0%
high	Home health, professional care	0.0%
high	Mental health services, psychiatric	2.7%
high	Mental health services, psychological	5.8%
high	Nutritional counseling	0.3%
high	Oral health care	1.2%
high	Substance abuse services (outpatient and residential)	6.0%
high	Treatment adherence services	4.0%
med	Drug reimbursement, medications	0.0%
med	Health/education/risk reduction	0.0%
med	Home health, specialized care	0.0%
med	Rehabilitation services	0.0%
low	Drug reimbursement, local	0.0%
low	Inpatient personnel costs	0.0%
low	Residential or in-home hospice	0.8%
#2	**Removal of Barriers**	**10.7%**
high	Food bank/home delivered meals/nutritional supplements	1.8%
high	Housing assistance/housing services	4.4%
high	Transportation services	4.0%
med	Child care services	0.5%
med	Client advocacy	0.0%
high	Emergency financial assistance	0.0%
med	Outreach services	0.0%
#3	**Patient Care Coordination**	**11.1%**
high	Case management, psychosocial	9.6%
high	Housing related services	0.0%
high	Translation/interpretation (other support services)	0.6%
low	Case management, inpatient (medical)	0.7%
low	Referral for health care/supportive services	0.2%
#4	**Economic Well-Being Measures**	**1.0%**
med	Health insurance	0.0%
med	Legal services	0.9%
med	Workforce entry/re-entry	0.0%
low	Child welfare services, foster care	0.0%
low	Child welfare services, parenting education	0.0%
low	Permanency planning	0.1%
#5	**Enhancement Service Options**	**1.4%**
med	Psychosocial support services, HIV support	1.4%

PRIORITY	SERVICE CATEORIES	2003 % srvcs TI & TII
med	Psychosocial support services, pastoral care	0.0%
low	Buddy/companion service	0.0%
low	Day/respite care/adults	0.0%
low	Home health, para-professional care	0.0%
low	Development assessment/children and infants	0.0%
low	Child welfare services, family preservation/unification	0.0%
low	Psychosocial support services, alternative services	0.0%
low	Psychosocial support services, child abuse/neglect counseling	
low	Psychosocial support services, recreational outings	0.0%
low	Psychosocial support services, caregiver support	0.0%
low	Psychosocial support services, bereavement counseling	0.0%
#6	**Program Support (may not exceed 5%)**	**1.7%**
#7	**Planning Council Support**	**2.8%**
#8	**Quality Management (may not exceed the lesser of 5% or $3,000,000)**	**2.0%**
#9	**Administrative Agency Costs (may not exceed 5%)**	**4.9%**
	Total Service Funds Allocated	**88.5%**
	Total Funding	**100.0%**

Other funding adjustments between 2002 and recommended 2003 reflects the reality of the funding experienced in Los Angeles County. As shown in Table 1-12 expenditures have not met funding in psychological, substance abuse, patient education, legal and, surprisingly, food bank. On the other hand expenditures have exceeded allocations for mental health, substance abuse, patient education, legal services, childcare, and peer or non-licensed support. Additional research has to be conducted to see if the lack of expenditures were a result of lower demand than expected or other structural reasons, such as inaccessibility of services, location, hours of operation, or other reasons.

Table 1-12 Trends in HIV/AIDS Funding

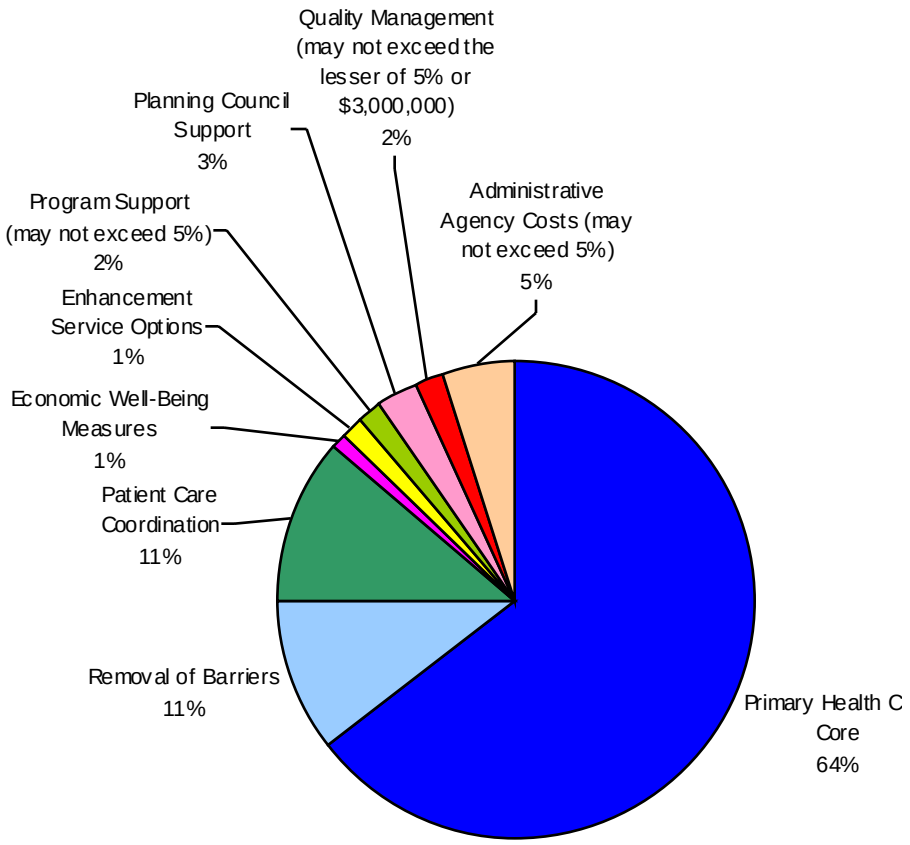
PRIORITIES	SERVICES	Year 10 Ryan White Title I and Title II Combined Priorities		Year 10 Title I, Title II and County Expenditures	Year 11 Ryan White Title I and Title II Combined Priorities		Year 11 Title I, Title II and County Estimated Expenditures*	Year 12 Ryan White Title I and Title II Combined Priorities		Year 12 Title I, Title II and County Estimated Obligations	Variance Year 12 Priorities and Obligations
		$	%	$	$	%	$	$	%	$	$
Priority #1	Outpatient Medical Services, Medical *	17,782,031	47.2%	17,825,784	17,641,371	46.5%	20,003,868	17,265,732	42.2%	20,055,007	2,789,275
	Outpatient Medical Services, Specialty*							449,584	1.1%	554,624	105,040
	Outpatient Medical Services, Psychiatric *							1,103,524	2.7%	1,197,664	94,140
	Hospice Services ****							326,970	0.8%	391,724	64,754
	Mental Health Services, Psychological	2,182,930	5.8%	2,041,832	2,167,796	5.7%	2,191,359	2,329,662	5.7%	2,422,647	92,985
	Nutritional Counseling *							122,614	0.3%	208,063	85,449
	Substance Abuse Services	2,351,102	6.2%	2,413,652	2,317,299	6.1%	2,375,862	2,452,275	6.0%	2,447,794	-4,481
	Oral Health Care	446,614	1.2%	556,835	448,510	1.2%	501,048	490,455	1.2%	563,919	73,464
	HIV/AIDS Treatment Adherence Services	1,489,548	4.0%	1,386,417	1,526,829	4.0%	1,396,653	1,634,850	4.0%	1,526,829	-108,021
	Patient Education	-	0.0%	-	-	0.0%	-	-	0.0%		
Priority #2	Case Management, Medical ***							286,099	0.7%	283,978	-2,121
	Referral ***							81,743	0.2%	106,020	24277
	Other Support Services, Translation/Interpretation	321,210	0.9%	286,728	234,492	0.6%	232,888	245,228	0.6%	244,587	-641
Priority #3	Legal Services **	388,587	1.0%	405,011	380,048	1.0%	388,587	367,841	0.9%	351,202	-16,639
	Permanency Planning **							40,871	0.1%	37,385	-3,486
Priority #4	Case Management, Psychosocial ***	4,045,101	10.8%	4,144,502	4,036,584	10.6%	3,991,725	3,923,641	9.6%	4,346,681	423,040
	Food Bank/Home Delivered Meals	703,607	1.9%	757,931	689,700	1.8%	741,966	735,683	1.8%	721,253	-14,430
	Transportation	1,544,990	4.1%	1,992,503	1,532,407	4.0%	1,948,599	1,634,850	4.0%	2,008,488	373,638
	Other Support Services, Childcare	315,528	0.8%	178,676	191,466	0.5%	153,461	204,356	0.5%	197,981	-6,375
	Housing Assistance ****	2,010,051	5.3%	8,152,217	1,980,917	5.2%	6,895,450	1,798,335	4.4%	6,793,720	4,995,385
Priority #5	Psychosocial Support Services, Peer Support	617,415	1.6%	501,430	542,414	1.4%	535,921	572,198	1.4%	557,992	-14,206
	SUBTOTALS FOR PRIORITIES 1-5	34,198,714	90.8%	40,643,518	33,689,833	88.8%	41,357,387	36,066,511	88.2%	45,017,558	8,951,047

* Expenditures are estimates because not verified prior to year end closing

Recommended 2003 RW TI and TII Allocation

In summary, for Ryan White Title I and Title II funds, the recommended distribution of funds within the five continuum of care categories is shown in Figure 1-37. Following the service priorities, the primary health care core receives nearly two-thirds of the funding. That is followed by the second priority, Removal of Barriers with 11% of the allocations. The third priority, Patient Care Coordination, also received a 11% of the funding. Economic Well-being and Enhancement Services, the fourth and fifth priorities, each receive about 1% of the CARE Act-funded allocations.

Figure 1-37 Resource Allocations for 2002



Minority AIDS Initiative (MAI)

Minority AIDS Initiative (MAI) funding has been used to reduce disparities and to improve access to services for communities of color. In 2002, over 80% of the funds were allocated to outpatient care and targeted to African American and Latino clients.

A majority of MAI funding is allocated to outpatient/medical and dental care (81%). To help persons access services and obtain benefits, about 14% of the MAI funds have been allocated to psychosocial case management.

In response to demand and lack of dental services for communities of color, about 2% of the MAI funds were targeted toward improving dental care in communities of color. In 2002, consistent with program guidelines, 5% of the MAI funds were used for grantee administration.

SPECIAL POPULATIONS

The following section presents the profile of eleven special populations of PLWH/A in Los Angeles County. These are special populations have unique needs and challenges to obtaining HIV services and or populations that are disproportionately impacted by the HIV epidemic. For instance, as shown in Table 1-13, MSM of Color represent about 2% of the Los Angeles County population, however, they account for over 58% of the PLWH/A. The table also shows that among the MSM of Color, almost 15% are living with HIV/AIDS.

Table 1-13 Special Population Estimates[1]

Special Population	Estimated population in Los Angeles County	Estimated Percent of Total Los Angeles County Population	Estimated number living with AIDS	Estimated number with HIV / AIDS	Estimated % of Total Pop PLWH/A	% PLWH/A
TOTAL POP	**9,846,713**	**100.0%**	**16,536**	**52,512**	**0.5%**	**100.0%**
MSM of Color	204,738	2.1%	7,003	30,553	14.9%	58.2%
MSM- Anglo	115,134	1.2%	5,951	14,560	12.6%	27.7%
Recently Incarcerated	476,345	4.8%	4947	12,861	2.7%	24.5%
Women of Childbearing Years	2,661,304	27.0%	1,358	6,414	0.2%	12.2%
Youth 13-24	1,660,472	16.9%	735	6,378	0.4%	12.1%
IDU	120,000	1.2%	2,532	12,252	10.2%	10.0%
Non-IDU Substance Users	218,954	2.2%	2,053	5,337	2.4%	10.2%
Homeless	165,586	1.7%	235	7,571	4.6%	14.4%
Chronically Mentally Ill	343,480	3.5%	1,986	5,163	1.5%	9.8%
Transgender	10,500	0.1%	565	1,470	14.0%	2.8%
Undocumented	766,667	7.8%	1,014	2,637	0.3%	5.0%

1 Estimates for the special populations were provided by the HIV Epidemiology Program, Los Angeles County Department of Health Services

Each of the eleven special populations is profiled in the following text. Attachment 12 compares demographic data between groups based on different data sources, including OAPP service utilization data, 2002 Needs Assessment Survey, 2001 APLA Client

Survey, 2000 to 2002 SHAS, LAC+USC African American Men's Study, and 2001 LA Transgender Health Study.

Men Of Color Who Have Sex With Men (MSMC)

African American MSM - Demographics

A demographic profile of African American MSM is created reviewing five databases: OAPP Service Utilization Data Collection System (N=1,680), LAC+USC 5P21 African American Study (N=250), APLA (N=137), SHAS (N=70; only PLWA), and the 2002 Needs Assessment Survey (N=31). Each one contributes information about the community using different approaches and methodologies. The following section highlights the findings from the various data.

- According to the OAPP service utilization data, 82% of the African American MSM living with HIV/AIDS live in three SPAS, the South SPA (32%), Metro SPA (30%) or South Bay-Long Beach SPA (20%).
- Ninety-eight percent (98%) of African American MSM living with HIV/AIDS identify as male and the other 2% identify as transgender (OAPP service utilization data). The APLA study has the same gender breakdown. The LAC+USC study is likely to have oversampled transgender individuals living with HIV/AIDS with 6% of the African American participants reporting transgender.
- Ninety-three percent (93%) are between the ages of 25 and 54 years, 5% are 55 years or older, and less than 3% are 24 years or younger (OAPP service utilization data). The APLA sample is slightly older with 13% being 50 years or older.
- All studies indicate that that a majority of the African American MSM living with HIV/AIDS have some college education or higher.
- Depending on the study, between 70% and 80% of African American MSM report being single. SHAS reports 86% of African American MSM living with AIDS report being single.
- Twelve percent (12%) of African American MSM living with HIV/AIDS in the LAC+USC study report being employed. In the 2002 Needs Assessment Survey, it is higher with 17% reporting employment either part or full-time.
- The vast majority (about 95%) of African American MSM living with HIV/AIDS have annual incomes of $26,000 or less in all the studies, which is below the 300% poverty level--the usual criteria for CARE Act eligibility.
- While the different surveys of African American MSM do not have the same question about incarceration, all report a high percentage of African American MSM living with HIV/AIDS have had some history of incarceration. Sixty-three percent (63%) of African American MSM living with HIV/AIDS report a history of being incarcerated in the LAC+USC study, and 40% in the APLA study. In SHAS, about 40% of African American MSM living with AIDS have been arrested or spent time in jail, detention or prison for longer than 24 hours at some point in their life. In the 2002 Needs Assessment Survey, a quarter (26%) of African American MSM living with HIV/AIDS have been incarcerated within the last two years.
- Insurance status varies by study, and the number reported to have insurance coverage ranges between 12% and 44%. According to OAPP service utilization data, nearly half of the African American MSM living with HIV/AIDS currently do not have any

health insurance (44%). In the LAC+USC study, 12% of the African American MSM living with HIV/AIDS report currently not having health insurance. Eighteen percent (18%) of the APLA sample report not having health insurance. In the SHAS study, 19% of the African American MSM living with AIDS report not currently having health insurance. Thirty-two percent (32%) of the 2002 Needs Assessment Survey African American MSM living with HIV/AIDS report not having insurance.

- According to the LAC+USC study, the insured mostly have MediCal (77%) followed by state funded assistance programs (16%). In the APLA study, 48% have MediCal and 44% have Medicare and with only 11% having private insurance. In the 2002 Needs Assessment Survey, they mostly report having MediCal (42%) or Medicare (26%).

Stage of Infection

- In all surveys, about half the African American MSM living with HIV /AIDS have been living with HIV for eight years or longer.
- According to the 2002 Needs Assessment Survey, 53% of the African American MSM living with HIV and AIDS report disabling symptoms. In the 2002 NA survey, more than half of the men have been diagnosed with AIDS (52%) and a quarter of these men (25%) have been living with AIDS for six years or longer.
- According to the 2002 Needs Assessment Survey, 60% of the African American MSM living with HIV/AIDS report having better physical health now than when they first sought treatment for their HIV, compared to 61% of all PLWH/A. Half of them (50%) are more likely to say they currently have good to excellent physical health.
- The African American MSM living with HIV/AIDS in the APLA study are more likely to report being healthier, with 76% saying they currently have good to excellent health. Forty-one percent (41%) feel they are doing better health wise today than they were a year ago, and 44% are doing about the same.

Medication Adherence

Based on the 2002 Needs Assessment Survey, nearly half of the African American MSM living with HIV/AIDS (48%) have a history of taking antiretrovirals or protease inhibitors, compared to 62% of all PLWH/A. More than three-quarters (79%) report skipping or ending their medication regimen. The primary reasons for they skipped medications were because they forgot (30%), followed by running out of the medications (26%), or because they were hard to coordinate with food (26%).

Ninety percent (90%) of the APLA sample of African American MSM living with HIV/AIDS are currently prescribed medications. However, more than two-thirds (69%) feel the side effects have bothered them and may have affected their adherence.

According to the SHAS data, over a third (37%) of the African American MSM PLWA were not able to take the HIV/AIDS medicines exactly the way their doctor told them to take it. Reasons for missing their doses include forgetting to take them and side effects.

Nearly two-thirds of the population (63%) also have taken a "drug holiday" from their antiretroviral medications in the past twelve months.

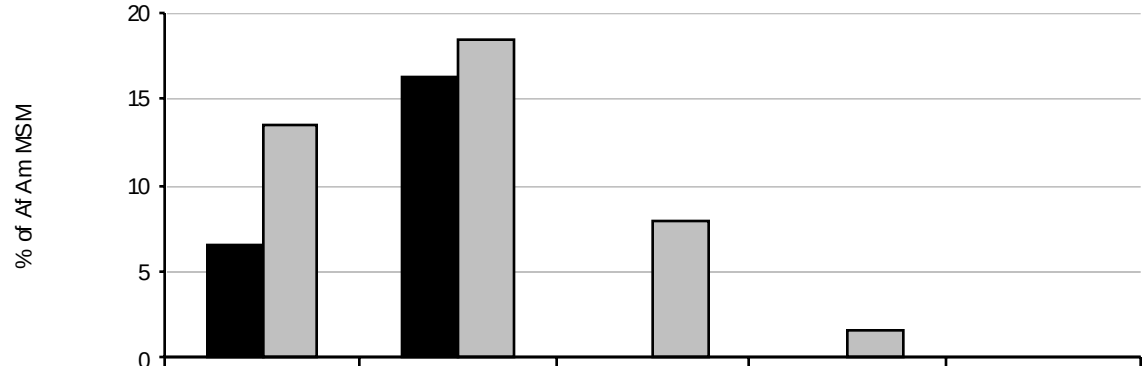
Co-Morbidities

According to SHAS data, 15% of the African American MSM living with AIDS have tested positive for TB skin test, and slightly less than 2% have active TB. These are very low numbers compared to the Latino MSM in the same study.

According to the SHAS data, about 40% of African American MSM living with AIDS report gonorrhea (41%) and syphilis (40%). This is a higher rate that other ethnic populations. According to the LAC+USC study report, two thirds of the African American MSM living with HIV/AIDS report ever having gonorrhea while 36% reporting having had syphilis. In the 2002 Needs Assessment Survey, when limited to the past two years, few African American MSM living with HIV/AIDS report having been diagnosed with an STD. They are more likely, though, to have been diagnosed with hepatitis (A, B or C) (16%) or syphilis (13%).

According to the 2002 Needs Assessment Survey and the LAC+USC study, between 16% and 18% of African American MSM living with HIV/AIDS report a history of injection drug use. In the OAPP service utilization data, 7% of the population believe they contracted HIV thought injection drug usage. Figure 1-38 shows the usage of injectable substances in the last six months as reported in the 2002 Needs Assessment Survey and the APLA study. African American MSM living with HIV/AIDS have average or below average substance usage compared to the general population. Crack tends to be the drug of choice, with an average of 17% of the population using it in the last six months.

Figure 1-38 Injectable Substance Usage in Last Six Months Among Af Am MSM



	Crystal Meth	Crack	Cocaine	Heroin	Speed
2002 Survey	6.5	16.1		0.0	0.0
APLA	13.4	18.4	8.0	1.6	

The 2002 Needs Assessment Survey also reports that 39% of African American MSM living with HIV/AIDS have consumed alcohol within the last six months with 19%

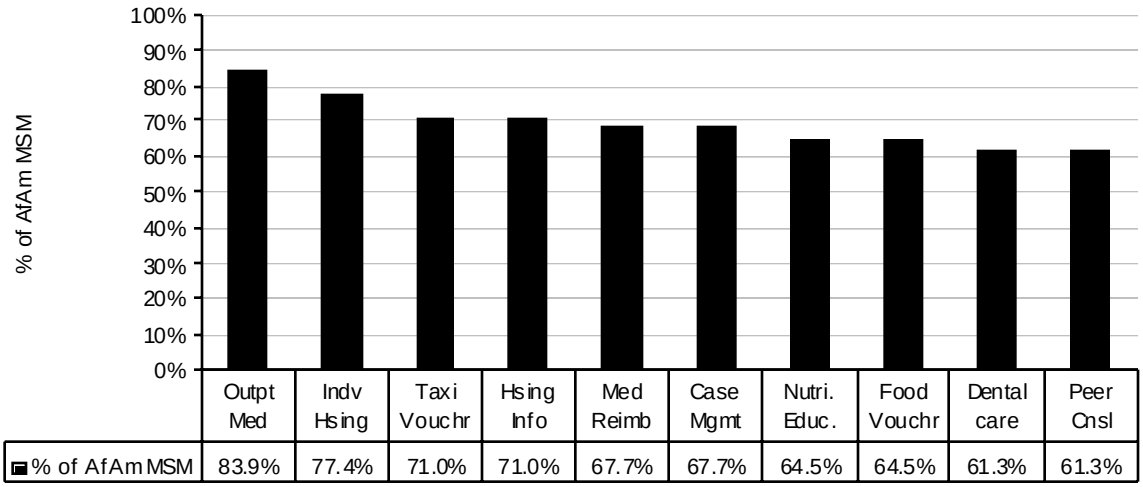
drinking once a week or more. More than half of the APLA sample (56%) report using marijuana in the last six months, with 17% saying they use it almost every day.

Eight percent (8%) of the African American MSM living with HIV/AIDS in the LAC+USC study have been homeless. According to the 2002 Needs Assessment Survey, African American MSM have a higher than average two-year history of being in transitional housing (32%) or homeless (23%). In the APLA sample, 9% of the African American MSM living with HIV/AIDS were homeless in the last six months and 13% of the sample believe they are at risk to being homeless in the next three months.

Top Service Need

Based on the 2002 Needs Assessment Survey, Figure 1-39 shows the top service needs for the African American MSM. Consistent with the general PLWH/A population, the African American MSM report outpatient medical care as their greatest need. Their other top five needs are independent housing (77%), taxi vouchers (71%), housing information (71%), and medication reimbursement (68%). The high need for housing services is connected to their high numbers of homelessness and usage of transitional housing. The need for medication assistance is related to the relatively large percent (32%) with no form of health insurance.

Figure 1-39 Top Service Needs for African American MSM



Barriers

Using a five point scale where "1" indicates a very small problem in seeking care and a "5" represents a big problem, participants were asked to rate 30 items in terms of the level of difficulty they represented for them when trying to access care. Table 1-14 shows the top five reasons along with the average score indicating the size of the barrier each of the items represented for them.

Four of the top five barriers for the African American MSM are individual barriers, none are structural and one is organizational. The largest problem experienced was not

knowing a service or treatment was available to them (81%) and they rated it as a moderate problem. That was followed by 81% citing providers made them feel like a number (an organizational barrier) as, on average, a moderate barrier.

Table 1-14 Barriers to Care

REASON	% with Problem	Average Score 5=very big 1=very small
Not knowing service or treatment was available to me	80.6%	3.1
Feel like a number	80.6%	2.9
Denial	77.4%	3.1
State of mind	77.4%	3.1
Not knowing location	74.2%	3.1

Latino MSM

The profile of Latino MSM in the continuum of care is created from four databases: OAPP service utilization data (N=2,819), APLA (N=333), SHAS (N=140; only PLWA), and the 2002 Needs Assessment Survey (N=37). Through different approaches and methodologies, each one contributes information about the community. The following section highlights the findings from the various data.

- According to the OAPP service utilization data, Latino MSM are more likely to live in the Metro SPA (44%). San Fernando Valley, San Gabriel Valley, South, East and South Bay-Long Beach--each have about 9-11% of the Latino MSM population.
- Ninety-eight percent (98%) identify as male and the other two identify as transgender (OAPP service utilization data). In the APLA study, three percent (3%)of the sample identify as transgender.
- Amongst the different ethnic groups, the Latino MSM are a little younger. Ninety-two percent (92%) are between the ages of 25 and 54 years and 4% are 55 years or older. About 6% are 24 years or younger (OAPP service utilization data). The APLA sample shows slightly younger with 3% Latino MSM of 24 years or younger, and 10% are between the ages of 25-29.
- Latino MSM have the least amount of education. About a third of the population (31%) did not graduate from high school. The 2002 Needs Assessment Survey and APLA survey report that less than half have had some college education or higher (41%).
- Based on the 2002 Needs Assessment Survey, Latino MSM PLWA are more likely to be partnered than other MSM.
- Based on the 2002 Needs Assessment Survey, Latino MSM living with HIV/AIDS are also more likely to work; 27% report being employed either part or full-time.
- According to the APLA study, Latino MSM have the smallest incomes with 56% with either no income or less than $8,500 annually. Other surveys report that over 90% of Latino MSM living with HIV/AIDS have an income that would allow them to obtain CARE Act-funded services.

- Less than a third of Latino MSM PLWA (28%) have been arrested or spent time in jail, detention or prison for longer than 24 hours at some point in their life (SHAS). Nineteen percent (19%) of Latino MSM living with HIV/AIDS have been incarcerated within the last two years (2002 Needs Assessment Survey).
- Within the MSM population, Latinos are more likely to not have health insurance than other ethnic groups. According to OAPP service utilization data, nearly two-thirds (62%) currently do not have any health insurance. In the 2002 Needs Assessment Survey, 32% of Latino MSM living with HIV/AIDS report not currently having health insurance, a figure that is comparable to the APLA study (34%). Forty percent (40%) of the Latino MSM living with AIDS report currently not having insurance in the SHAS study.
- Those with health insurance primarily have MediCal. In the 2002 Needs Assessment Survey, 57% of Latinos with health insurance report receiving MediCal benefits and 30% report receiving Medicare benefits.

Stage of Infection

- Similar to the African American MSM, the 2002 Needs Assessment Survey shows 55% have been living with HIV for eight years or longer.
- According to the 2002 Needs Assessment Survey, among the MSM population, Latinos are more likely to report having disabling symptoms (73%). Sixty percent (60%) of the men have been diagnosed with AIDS and less than a quarter of these men (23%) have been living with AIDS for six years or longer.
- According to the 2000 Needs Assessment Survey, 55% of the Latino MSM living with HIV/AIDS report having better physical health now than when they first sought treatment for their HIV, compared to 61% of all PLWH/A. A quarter report (25%) their health as being worse than when first sought treatment. Three quarters (75%) of the Latino MSM in the APLA study report good to excellent general health. The Latino MSM living with AIDS in the SHAS data are more likely to say they currently have good to excellent physical health (48%).

Medication Adherence

Based on the 2002 Needs Assessment Survey, two-thirds (68%) of Latino MSM living with HIV/AIDS report having a history of taking antiretrovirals or protease inhibitors, compared to 62% of all PLWH/A. About three-quarters (73%) report skipping or ending their medication regimen. The primary reasons for their skipping their medications are because they forgot (41%), they didn't want to take them (27%) and side effects (22%).

In the APLA study, 83% of the Latino MSM living with HIV/AIDS are currently prescribed medications. Nearly three-quarters (74%) of the population are experiencing side effects that bother them and may affect their adherence.

According to the SHAS data, less than a third (31%) of the Latino MSM PLWA were not able to take the HIV/AIDS medicines exactly the way their doctor told them to. Reasons for missing their doses include forgetting to take them and side effects. Less than half of

the population (44%) have taken a "drug holiday" from their antiretroviral medications in the past twelve months.

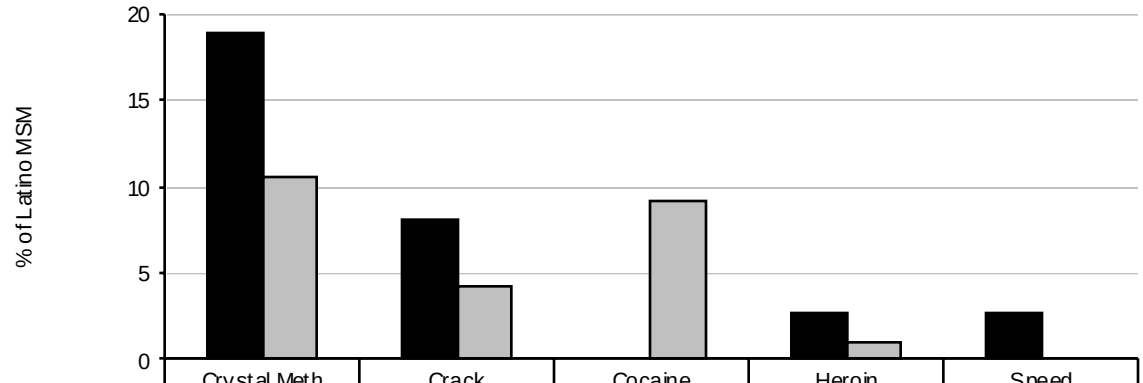
Co-Morbidities

SHAS has tuberculosis (TB) data for PLWA. Amongst the MSM living with AIDS, Latinos have the highest percentage (18%) who have tested positive for TB skin test and 4% have active TB.

According to the SHAS data, about a quarter Latino MSM living with AIDS have a history of having STDs – 26% reporting having had gonorrhea and 23% have had syphilis. In the 2002 Needs Assessment Survey, 24% of the Latino MSM living with HIV/AIDS have been diagnosed with hepatitis A or B and 14% have been diagnosed with hepatitis C in the last two years.

Among the Latino MSM living with HIV/AIDS interviewed in the 2002 Needs Assessment Survey, 5% report a history of injection drug use. This portion of the population is very comparable to the OAPP service utilization data which shows 4% of the sample believing they contracted HIV through injection drug use. Figure 1-40 shows the usage of injectable substances in the last six months as reported in the 2002 Needs Assessment Survey and the APLA study. Latino MSM living with HIV/AIDS report an above average usage of crystal meth and cocaine within the last six months. Four percent of the APLA sample have injected drugs in the last six months.

Figure 1-40 Injectable Substance Usage in Last Six Months



	Crystal Meth	Crack	Cocaine	Heroin	Speed
2002 Survey	18.9	8.1		2.7	2.7
APLA	10.5	4.3	9.2	1.0	

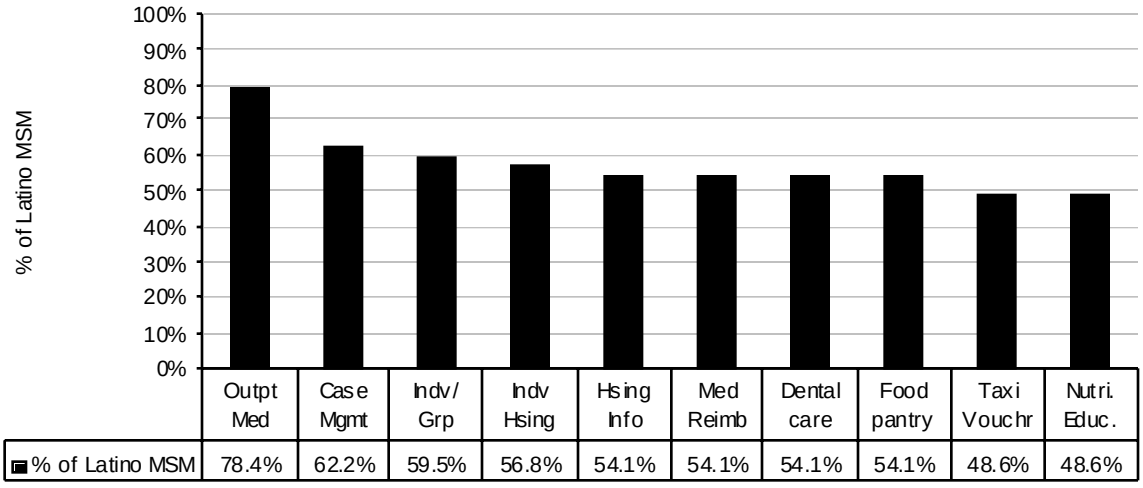
The 2002 Needs Assessment Survey also reports that 24% of Latino MSM living with HIV/AIDS have consumed alcohol within the last six months with 8% drinking once a week or more. Compared to the other ethnic MSM groups, fewer Latino MSM living with HIV/AIDS use marijuana, with typically 8% using it once a week ore more. Notably most self-reports of drug and alcohol use are low.

In the last two years, according to the 2002 Needs Assessment Survey, 24% of the Latino MSM living with HIV/AIDS have been homeless, representing the highest amongst the MSM population and for the Latino community in general. More than a quarter (27%) have used transitional housing in the last two years. In the APLA sample, 6% of the Latino MSM living with HIV/AIDS were homeless in the last six months, and 14% of the sample believe they are at risk to being homeless in the next three months.

Top Service Need

Based on the 2002 Needs Assessment Survey, Figure 1-41 shows the top service needs for the Latino MSM living with HIV/AIDS. The percentage of need for services are on average lower than the other ethnic MSM populations. Consistent with the general PLWH/A population, they report outpatient medical care as their greatest need (78%). Their other top five needs are case management (62%), mental health (60%), independent housing (57%) and housing information (54%). The expressed need for mental health compliments the comments expressed in the community forums regarding a shortage of Spanish speaking therapists. The need for housing services is related to the quarter (24%) of Latino MSM that have been homeless and 27% that have used transitional housing in the last two years. The need for medication assistance (54%) is related to the relatively large percent (32%) with no form of health insurance.

Figure 1-41 Top Service Needs for Latino MSM



Barriers

Using a five point scale where "1" indicates a very small problem in seeking care and a "5" represents a big problem, participants were asked to rate 30 items in terms of the level of difficulty they represented for them when trying to access care. Table 1-15 shows the top five reasons, along with the average score, indicating the size of the barrier each of the items represented for them.

The top five barriers for the Latino MSM are diverse: two are structural barriers (rules and regulations), two are organizational barriers (provider sensitivity) and one individual

barrier (knowledge). On average, fewer Latino MSM reported problems in getting services than African American MSM, and they also rated those problems slightly lower. The largest challenge experienced by 76% of the Latino MSM living with HIV/AIDS was the organization barrier regarding "the sensitivity of the organization and person providing services to me regarding my issues and concerns" and they rated it as a moderate problem. That was followed by 73% reporting a moderate structural barrier regarding "the amount of time needed to wait to get an appointment or to see someone".

Table 1-15 Barriers to Care

REASON	% with Problem	Average Score 5=very big 1=very small
Sensitivity of organization regarding my issues & concerns	75.7%	2.9
Amount of time to wait to get an appointment or to see someone	73.0%	2.9
Discrimination experienced by persons or organization providing services	70.3%	2.9
Too much paperwork or red tape	70.3%	2.7
Not knowing service or treatment was available to me	67.6%	3.3

Anglo MSM

The demographic profile of Anglo MSM in the continuum of care is based on data from four sources: OAPP Client Service Utilization Data Collection System (N=2,875), APLA (N=557), SHAS (N=49; only PLWA), and the 2002 Needs Assessment Survey (N=47). Each one contributes information about the community using different approaches and methodologies. The following section highlights the findings from the various data.

- According to the OAPP service utilization data, 47% of the Anglo MSM living with HIV/AIDS live in Metro SPA, 21% in South Bay-Long Beach SPA, and 14% in San Fernando Valley SPA. Less than 19% of the Anglo MSM live in the other five SPAs.
- Less than one percent identifies itself as transgender (OAPP service utilization data).
- The mean age of the Anglo MSM is 46 (2002 Needs Assessment Survey). The OAPP service utilization data shows that 90% of Anglo MSM are between the ages of 25 and 54 years, 9% are 55 years or older, and 1% are 24 years or younger. The age group in the APLA sample is a little older with 25% being 50 years old or older.
- In the 2002 Needs Assessment Survey sample, a majority (64%) of the Anglo MSM living with HIV/AIDS have some college education or higher, with 19% of the sample reaching graduate level. In the APLA study, 82% of Anglo MSM living with HIV/AIDS have some college education or higher, with 19% reaching graduate level.
- In the APLA study, 64% living with HIV/AIDS are single and 28% are partnered. SHAS data shows 90% of Anglo MSM living with AIDS report being single.
- According to the 2002 Needs Assessment Survey, 17% of Anglo MSM living with HIV/AIDS are employed either part or full-time, and 19% are retired.
- In the 2002 Needs Assessment Survey, 85% of those living with HIV/AIDS have annual incomes of $26,000 or less. The APLA study shows that 92% of the Anglo MSM living with HIV/AIDS have annual incomes of $26,000 or less. While the OAPP service utilization data reports 92% of the Anglo MSM living with HIV/AIDS

are living within the 300% federal poverty level (FPL), the APLA study shows that 75% of Anglo MSM living with HIV/AIDS are within the FPL, and 72% of Anglo MSM living with AIDS are within the 300% FPL.

- All studies show that about a fifth of Anglo MSM have been incarcerated. In the APLA study, 22% of Anglo MSM living with HIV/AIDS have ever been incarcerated. In SHAS, about 29% of Anglo MSM living with AIDS have been arrested or spent time in jail, detention or prison for longer than 24 hours at some point in their life. In the 2002 Needs Assessment Survey, 21% of Anglo MSM living with HIV/AIDS have been incarcerated within the last two years.
- According to OAPP service utilization data, 51% of the Anglo MSM living with HIV/AIDS currently do not have any health insurance. This is high compared to 17% in the 2002 Needs Assessment Survey and 15% in the APLA. In the SHAS study, 26% of the Anglo MSM living with AIDS do not have health insurance.
- According to OAPP service utilization data, 29% of Anglo MSM living with HIV/AIDS sample have MediCal or Medicare, and 12% have private insurance. In the 2002 Needs Assessment Survey, 54% of the insurance have MediCal or Medicare while 13% of the insured have private insurance.

Stage of Infection

- Amongst other MSM living with HIV/AIDS, a larger percent of Anglos have been positive for longer than eight years. The 2002 Needs Assessment Survey reports 61% and the APLA study reports 63% of Anglo MSM living with HIV and AIDS for eight years or longer.
- According to the 2002 Needs Assessment Survey, 60% of the Anglo MSM living with HIV and AIDS report disabling symptoms. Two-thirds (66%) of the men have been diagnosed with AIDS and more than half (53%) of these men have been living with AIDS for six years or longer.
- The majority of Anglo MSM are doing well. According to the 2002 Needs Assessment Survey, 53% of the Anglo MSM living with HIV and AIDS report having better physical health now than when they first sought treatment for their HIV, compared to 61% of all PLWH/A. More than two thirds (69%) are more likely to say they currently have good to excellent physical health. In the APLA data, 57% say they are doing the same and 23% say they are doing better than a year ago. Nearly three-quarters (72%) of that population say their general health is currently good to excellent. In the SHAS data, 55% of the Anglo MSM living with AIDS report having good to excellent physical health.

Medication Adherence

Based on the 2002 Needs Assessment Survey, Anglo MSM living with HIV/AIDS are more like to have a history of taking antiretrovirals or protease inhibitors (77%) compared to 62% of all PLWH/A. Amongst MSM, Anglos are less likely to skip or end their medication regimen, with 28% reporting never skipping their medications. The primary reasons for skipping their medications are because they forgot (45%), followed by not wanting to take them (26%) and side effects (19%).

In the APLA study, 89% of the Anglo MSM living with HIV/AIDS are currently prescribed medications. Nearly a quarter (23%) of those currently on a regimen say no side effects have bothered them in the past six months, compared to 42% who say side effects have bothered them "a little bit."

According to the SHAS data, all (100%) Anglo MSM living with AIDS sample have a history of taking antiretroviral medications. Nearly half (45%) of the sample were not able to take the HIV/AIDS medicines exactly the way their doctor told them to. Reasons for missing their doses include forgetting to take them, not being able the afford the medications, and not able to fit the schedule for taking them into their daily lives. Sixty-nine percent (69%) of the population also have taken a "drug holiday" from their antiretroviral medications in the past twelve months.

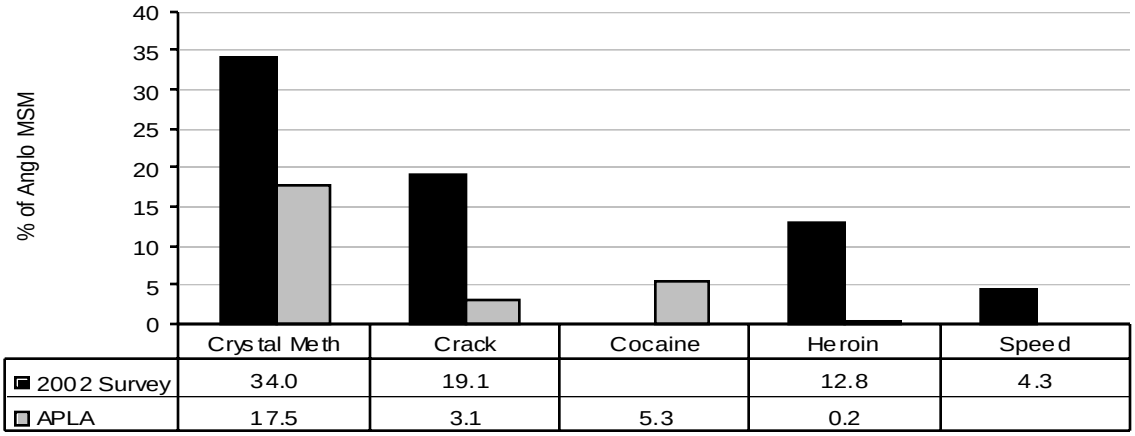
Co-Morbidities

According to SHAS data, 12% of the Anglo MSM living with AIDS have tested positive for TB skin test, but none have active TB. These are very low numbers compared to the Latino MSM with AIDS in the same study.

In the same study, 47% report a history of having gonorrhea (a higher rate that other ethnic populations), 40% have had syphilis and 24% have had hepatitis B. In the 2002 Needs Assessment Survey, when limited to the past two years, few Anglo MSM living with HIV/AIDS report having been diagnosed with an STD in the last two years. They are more likely to have been diagnosed with hepatitis (A or B) (15%) or genital herpes (13%). Only 4% of the population have been diagnosed with gonorrhea in the last two years.

According to the OAPP service utilization data, 8% of the population feel they contracted HIV through their injection drug use history. According to the 2002 Needs Assessment Survey, 40% of Anglo MSM living with HIV/AIDS report a history of injection drug use, compared to 23% of the total PLWH/A sample. Figure 1-42 shows the use of injectable substances in the last six months as reported in the 2002 Needs Assessment Survey and the APLA study. Crystal meth has the highest use with 34% of the 2002 Needs Assessment Survey sample of Anglo MSM living with HIV/AIDS reporting use of it in the last six months, compared to 18% of the same population in the APLA study.

Figure 1-42 Injectable Substance Usage in Last Six Months



	Crystal Meth	Crack	Cocaine	Heroin	Speed
2002 Survey	34.0	19.1		12.8	4.3
APLA	17.5	3.1	5.3	0.2	

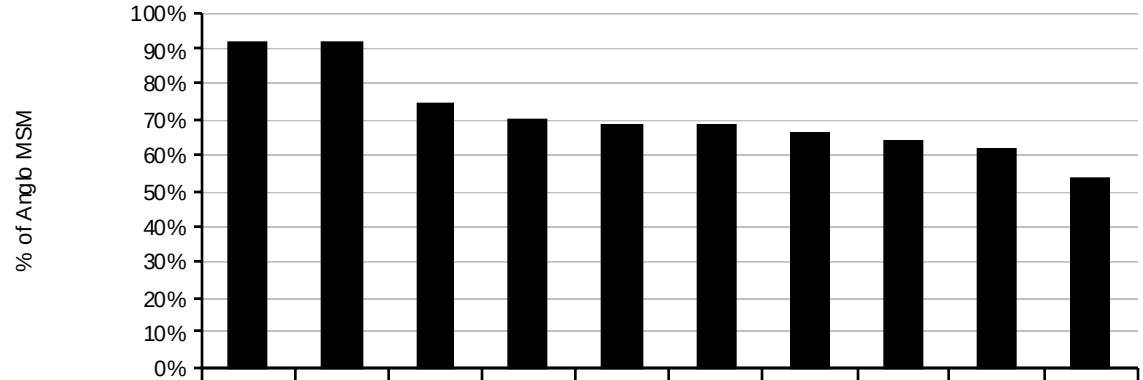
The 2002 Needs Assessment Survey also reports that 68% of Anglo MSM living with HIV/AIDS have consumed alcohol within the last six months with 9% drinking once a week or more. Nearly half of the sample have used marijuana in the last six months, with close to 20% smoking it once a week or more.

In the last two years, according to the 2002 Needs Assessment Survey, 21% of the Anglo MSM living with HIV/AIDS have been homeless and 23% have used transitional housing. In the APLA sample, 4% of the Anglo MSM living with HIV/AIDS were homeless in the last six months, and 13% of the sample believe they are at risk to being homeless in the next three months.

Top Service Need

Based on the 2002 Needs Assessment Survey, Figure 1-43 shows the top service needs for the Anglo MSM living with HIV/AIDS. They equally need outpatient medical care and dental care (92%), case management (75%), food services (70%) and independent housing (68%).

Figure 1-43 Top Service Needs for Anglo MSM



	Outpt Med	Dental care	Case Mgmt	Food pantry	Indv Hsing	Nutri. Educ.	Med Spec	Indv/ Grp	Med Reimb	Peer Cnsl
% of Anglo MSM	91.5%	91.5%	74.5%	70.2%	68.1%	68.1%	66.0%	63.8%	61.7%	53.2%

Barriers

Using a five point scale where "1" indicates a very small problem in seeking care and a "5" represents a big problem, participants were asked to rate 30 items in terms of the level of difficulty they represented for them when trying to access care. Table 1-16 shows the top five reasons along with the average score indicating the size of the barrier each of the items represented for them.

Three of the top five barriers for Anglo MSM living with HIV/AIDS are structural barriers, one is an individual barrier, and one is organizational. The largest problem experienced was not knowing a service or treatment was available to them (75%) and they rated it as a moderate problem. That was followed by 68% concerned of the amount of time necessary to wait to get an appointment as a small to moderate problem.

Table 1-16 Barriers to Care

REASON	% with Problem	Average Score 5=very big 1=very small
Not knowing service or treatment was available to me	74.5%	2.9
The amount of time I had to wait to get an appointment	68.1%	2.7
Experience or expertise of the person providing services	66.0%	2.7
Too much paperwork or red tape	57.4%	2.5
My ability to find my way though the system	57.4%	2.7

Recently Incarcerated

The demographic profile of the recently incarcerated in the continuum of care is created with the review of three databases. Each one contributes information about the community using different approaches and methodologies. The APLA study (N=329) is based on the participant ever being in a correctional system (probation, parole, secured detention, juvenile corrections, jail, prison, etc.) The SHAS (N=198) sample is based on participants who have ever been arrested and put in jail, detention or prison for longer than 24 hours. The 2002 Needs Assessment Survey (N=41) sample is based on the participant being incarcerated in the last two years. The APLA study and 2000 Needs Assessment involve PLWH/A and the SHAS study involves PLWA only. The following section highlights the findings from the various data.

- In the APLA study, 55% of the recently incarcerated live in the Metro SPA, 16% live in San Fernando Valley SPA, and 12% live in South SPA. In the SHAS study, 29% live in Metro SPA, 27% in South SPA, 14% in San Gabriel Valley, and 12% in San Fernando Valley SPA.
- In the 2002 Needs Assessment Survey, 85% are male, 12% are female and 3% are transgender. The APLA data is similar.
- According to the 2002 Needs Assessment Survey, the mean age of recently incarcerated is 41. There are 98% between the ages of 25 and 54 years, and those 55 years or older make up 2% of the population.

- Based on the 2002 Needs Assessment Survey, those incarcerated in the last two years are 32% African American, 32% Anglo, 24% Latino, and about 5% each of Native American and mixed races. In the APLA study, 42% are Anglo, 26% Latino, and 25% African American.
- According to the 2002 Needs Assessment Survey, 59% feel they contracted HIV by having sex with a man, 27% by injection drug use, and 5% by having sex with a woman.
- In the 2002 Needs Assessment Survey sample, 20% did not graduate from high school, 39% have a high school diploma as their highest level of education, and 41% have some college education or higher. In the APLA data, 14% did not graduate from high school, 26% have a high school diploma, and 61% have some college education or higher.
- According to the 2002 Needs Assessment Survey, 53% of those who were recently incarcerated in the last two years are currently living in an apartment/house they own or rent. Twenty-one percent (21%) are currently in transitional housing (e.g. "crashing" with someone without paying rent, a single resident occupancy or a half-way house). Three percent (3%) are currently homeless on the street or in a shelter. Though 87% say their living situation is safe and habitable, 26% say the living situation is not stable. Close to half (49%) of the sample have been in transitional housing and 64% have been homeless in the last two years. In the APLA study, 12% have been homeless in the last six months, and 16% say they are at risk of being homeless in next three months.
- According to the 2002 Needs Assessment Survey, 15% of recently incarcerated PLWH/A are employed either part or full-time, 20% are not working but looking for work and 5% are retired. In the SHAS study, 27% of recently incarcerated PLWA are currently employed.
- In the 2002 Needs Assessment Survey, 100% of recently incarcerated have annual incomes of $16,500 or less and 55% of them are making less than $8,600 a year. The APLA study shows similarly low incomes.
- The 2002 Needs Assessment Survey reports 39% are receiving SSI, 39% are receiving subsidized housing, 24% are receiving food stamps and 22% are receiving General Assistance.
- According to the 2002 Needs Assessment Survey, 29% of the recently incarcerated PLWH/A currently do not have any health insurance. The APLA study reports 21% of recently incarcerated PLWH/A are without health insurance.

Stage of Infection

- The 2002 Needs Assessment Survey shows 26% of the recently incarcerated PLWH/A have had HIV for three years or less compared to 16% of the general PLWH/A. More than half (51%) have lived with HIV for more than eight years.
- According to the 2002 Needs Assessment Survey, 58% of the recently incarcerated PLWH/A report disabling symptoms. A third report (32%) have received an AIDS diagnosis--comparable to APLA's study showing 35% with an AIDS diagnosis. A

majority (46%) of the recently incarcerated with an AIDS diagnosis have had AIDS less than three years.

- According to the 2002 Needs Assessment Survey, 59% of the recently incarcerated PLWH/A report having better physical health now than when they first sought treatment for their HIV, compared to 61% of all PLWH/A. About two-thirds (63%) are more likely to say they currently have good to excellent physical health.

Medication Adherence

Based on the 2002 Needs Assessment Survey, 68% of recently incarcerated PLWH/A have a history of taking antiretrovirals or protease inhibitors, compared to 62% of all PLWH/A. Fifteen percent (50%) have stopped taking their medicine, and 62% report having skipped their medications at least once a month. The primary reasons for their skipping their medications are because they forgot (49%), they did not want to take them (24%), because they ran out of medications (22%), and/or because they were homeless at the time (22%).

In the APLA study, 81% of the recently incarcerated PLWH/A are currently prescribed medications, and 68% report experiencing side effects that have bothered them.

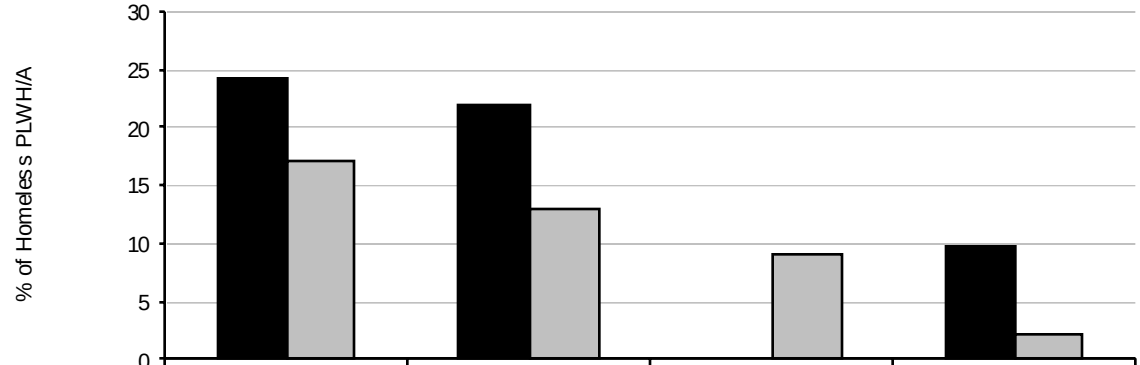
Co-Morbidities

According to SHAS data, 24% of the recently incarcerated PLWA have tested positive for TB skin, compared to 16% of the general PLWH/A. Five percent (5%) report having active TB.

In the 2002 Needs Assessment Survey, about a quarter of the recently incarcerated PLWH/A have been diagnosed with hepatitis A, B or C in the last two years.

According to the 2002 Needs Assessment Survey, 42% of the recently incarcerated PLWH/A report a history of injection drug use, compared to 23% of the total PLWH/A sample. Nine percent (9%) of the recently incarcerated PLWH/A in the APLA study say they have injected in the last six months, compared to 5% of the general PLWH/A. Figure 1-44 shows the use of injectable substances in the last six months as reported in the 2002 Needs Assessment Survey and the APLA study. Crystal Meth has the highest usage with about 25% of the 2002 Needs Assessment Survey and 17% of the APLA study using it in the last six months. Crack is also used frequently, as evidenced by 22% of the 2002 Needs Assessment Survey sample and 13% of the APLA sample.

Figure 1-44 Injectable Substance Usage in Last Six Months



	Crystal Meth	Crack	Cocaine	Heroin
2002 Survey	24.4	22.0		9.8
APLA	17.0	12.9	9.1	2.3

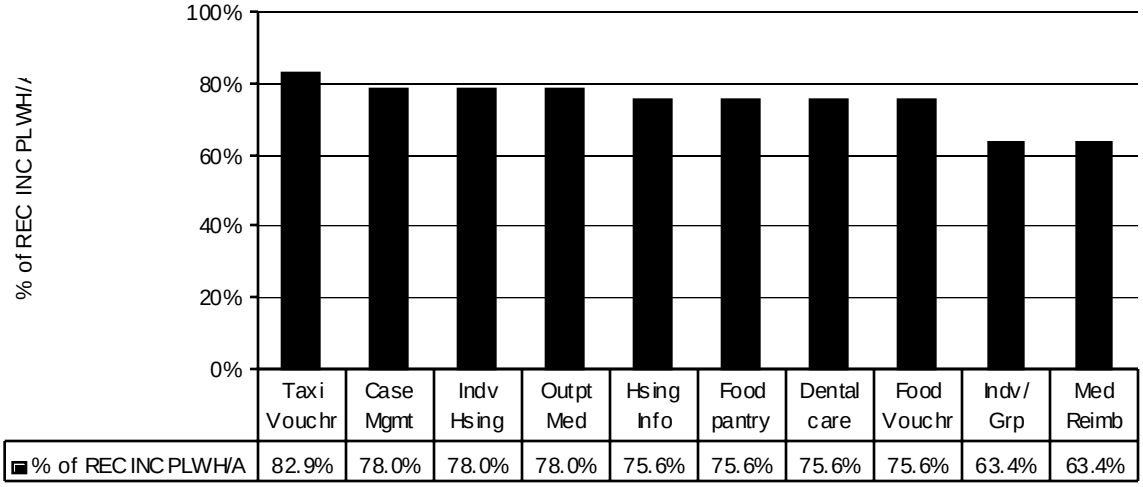
The 2002 Needs Assessment Survey also reports that more than half (51%) of the recently incarcerated PLWH/A have consumed alcohol within the last six months with 20% drinking once a week or more. Forty-four percent (44%) of the sample have used marijuana in the last six months with 24% smoking it once a week or more.

More than half (51%) of the recently incarcerated PLWH/A have received mental health services since they were diagnosed with HIV. Twenty percent (20%) have received inpatient mental health services, 42% have participated in group counseling or therapy with a professional, and 39% have had individual counseling or therapy with a professional. In the last two years, 50% have received a depression diagnosis and 30% have received an anxiety diagnosis. These services may be working when seeing that 59% of the recently incarcerated PLWH/A report good to excellent emotional health, and 59% report doing better emotionally today than when they first sought treatment for their HIV.

Top Service Need

Based on the 2002 Needs Assessment Survey, Figure 1-45 shows the top ten service needs for the recently incarcerated PLWH/A, which includes four primary health care core services, four from the removal of barriers priority, and the two patient care coordination services. The top five needs are: 83% need taxi vouchers, 78% case management, 78% independent housing, 78% outpatient medical care, and 76% need housing information services. Ironically, with the prevalence of mental health service usage among this population, they did not report it as a higher need service.

Figure 1-45 Top Service Needs for Homeless PLWH/A



Barriers

Using a five point scale where "1" indicates a very small problem in seeking care and a "5" represents a big problem, participants were asked to rate 30 items in terms of the level of difficulty they represented for them when trying to access care. Table 1-17 shows the top five reasons along with the average score indicating the size of the barrier each of the items represented for them.

Four of the top five barriers for recently incarcerated PLWH/A are individual barriers and the other is a structural barrier. Compared to the general PLWH/A sample, those incarcerated in the last two years report having more problems in getting services and they give those problems higher difficulty ratings. The largest problem experienced is not knowing a service or treatment was available to them, experienced by 88% of the sample and rated as a moderate to big problem.

Table 1-17 Barriers to Care

REASON	% with Problem	Average Score 5=very big 1=very small
Not knowing service or treatment was available to me	87.8	3.4
Amount of time to wait to get an appointment or see someone	85.4	3.0
Not knowing who to ask for help	82.9	3.2
The state of mind or mental ability to deal with treatment	80.5	3.1
Not knowing location of the services	80.5	2.9

Women of Childbearing Years

For the purpose of this report, women of childbearing age (WCBA) including women between the ages of 13 to 49. Fifty-seven (5) women (23%) between these ages participated in the 2002 Needs Assessment Survey and 2,743 (14%) accessed care as recorded in the OAPP service utilization data.

Table 1-18 presents the age, racial/ethnic, risk group and geographic distribution for the women of childbearing age living with HIV/AIDS. It indicates that:

- About 10% of the WCB are young adults, 24 years or younger. Young women, especially those under 18 years of age, present specific service needs and legal considerations regarding possible pregnancies and access to medical treatment.
- WCBA living with HIV/AIDS are mostly women of color. Anglo WCBA represent less than 13% of the participants in the 2002 Needs Assessment Survey and about 16% of those accessing care as reported by the OAPP service utilization data.
- IDU transmission accounts for about 11% to 14% of the cases among WCBA. About 20% of the WCB accessing care are unaware of their mode of transmission.
- WCBA living with HIV/AIDS live mostly in the Metro and South SPAs.

Table 1-18 Women of Childbearing Years (13-49): Demographic Profile

\	NA 2002		OAPP Service Utilization Data	
	N=57	%	N=2743	%
AGE GROUP				
13-19	2	3.5%	113	4.1%
20-24	3	5.3%	155	5.7%
25-49	52	91.2%	2475	90.2%
RACE/ETHNICITY				
African American/Black	23	40.4%	956	35.9%
Anglo/White	7	12.3%	414	15.6%
API	3	5.3%	44	1.7%
Latino	23	40.4%	1131	42.5%
Other/mixed	1	1.8%	115	4.4%
MODE				
IDU	8	14.0%	235	11.3%
Hetero	149	86.0%	1437	68.8%
Other/unknown	0	0.0%	416	19.9%
SPA				
Antelope Valley	0	0.0%	67	2.7%
San Fernando Valley	3	5.3%	293	11.7%
San Gabriel Valley	6	10.5%	230	9.1%
Metro	13	22.8%	566	22.5%
West	2	3.5%	93	3.7%
South	24	42.1%	663	26.4%
East	2	3.5%	195	7.8%
South Bay–Long Beach	7	12.3%	408	16.2%

In addition, not shown in the table is that:

- Almost half (44%) of the 2002 Needs Assessment WCBA have less than a high school education and about 30% are employed in some capacity.
- Based on the 2000 Needs Assessment Survey, more than half (55%) of the WCBA have an annual income of $8,600 and 94% have an annual income of 300% of federal poverty level. Among the WCBA in the OAPP service utilization data, 91% live within the 300% poverty level.
- Based on needs assessment data, WCBA are more likely than other PLWH/A to have health insurance, with close to half (49%) reporting having MediCal/Medicaid.

Nineteen percent (19%) of WCBA report not having health insurance, compared to 28% among all PLWH/A. However, the OAPP service utilization data shows that approximately 36% of WCBA have no health insurance, and about 37% report having MediCal/Medicaid. This may be explained by the relatively low percentage (23%) of clients reported in the OAPP service utilization data who seek care through private providers. The OAPP service utilization data is more likely than the Needs Assessment data to reflect the uninsured PLWH/A

- Based on the 2002 Needs Assessment, the majority of the WCBA live with other adults or children, and 67% report having children. More than 20% of the WCBA consider their current housing situation unstable, and 9% feel it is unsafe.

Stage of Infection

As expected, fewer of the WCBA have been told their infection has progressed to AIDS. In the 2002 Needs Assessment Survey, 55% of PLWH/A have been told they have progressed to AIDS, while 47% of the WCBA report having been told that their HIV had progressed to AIDS.

More than one third (36%) of the WCBA have known their HIV status for less than six years and 47% report currently being asymptomatic. Thirty-four percent (34%) have known they were positive for less than six years, 43% report being asymptomatic, and about 45% have had CD4 counts below 200.

Table 1-19 Length of HIV Infection

	Number	Percent (%)
Less than 3 years	7	13.2%
3 to 6 years	12	22.6%
6 to 12 years	26	49.1%
More than 12 years	8	15.1%
Total	53	100.0%

WCBA are more likely than all PLWH/A to say that their physical and emotional health is good to excellent. More than 60% of the WCB feel that their physical and emotional health is good or excellent and, over 64% believe their physical health is currently better than when they were first diagnosed.

Medication Adherence

Slightly less WCBA (59%) than all PLWH/A (62%) report currently taking medicines for their HIV infection. Out of the 34 WCBA who are currently taking medications, only seven (21%) report adhering to the scheduled prescribed by the doctor. Five (5) WCBA report suspending the medication all together, and 9 WCBA report weekly interruptions.

Table 1-20 shows the top five reasons that the WCBA report for not taking their medications as prescribed. For WCBA, similarly to all PLWH/A, forgetting to take the medications is the first reason they do not adhere to their medication regimen.

Table 1-20 Top Reasons for Skipping Medications

Top Reasons	N=	Percent
Forgot	16	47.1%
Side effects	11	32.4%
Difficult schedule	10	29.4%
Just did not want to take them	8	23.5%
Didn't want others to see	7	20.6%

Co-Morbidities

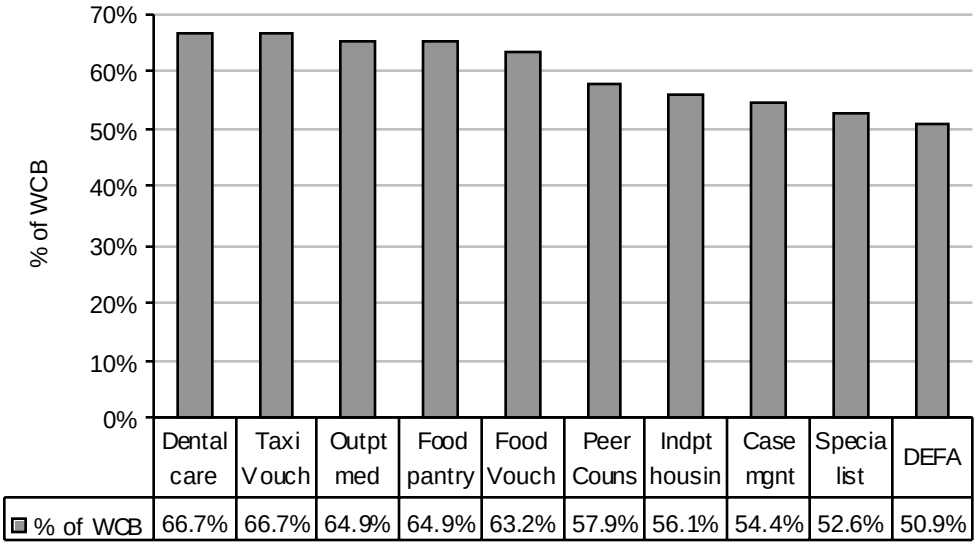
Six percent (6%) of the WCB have had hepatitis A or B and 4% have had hepatitis C. Thirty-two percent (32%) have had yeast infections, 6% have had genital warts, 5% have had chlamydia, and 4% have had syphilis.

Alcohol is the most common substance used by women, with about one quarter reporting any use within the last six months. This is comparable to the 25% of WCBA who report history of substance use in the OAPP service utilization data. Marijuana is the second most commonly used substance, with about 14% of the WCBA reporting using it in the last six months.

Top Service Need

Figure 1-46 shows the top service needs for the WCBA who completed the 2002 Needs Assessment Survey. WCBA ranked the need for services slightly different than the general PLWH/A population. For instance, while outpatient medical care is the number one need among all PLWH/A, WCBA identify it as their third service need, behind dental care and taxi vouchers. Similarly, case management drops from an overall rank of fourth to eighth among WCBA. WCBA report DEFA as a greater need than other PLWH/A.

Figure 1-46 Top Service Needs for WCBA



Barriers

Using a five point scale where "1" indicates a very small problem in seeking care and a "5" represents a big problem, participants were asked to rate 30 items in terms of the level of difficulty they represented for them when trying to access care. Table 1-21 shows the top five reasons along with the average score indicating how important a barrier each of the items represented for them.

Eighty-three percent (83%) of the WCBA felt that their own denial was the biggest problem in accessing care, with an average score of 3.2, representing a moderate to big problem for them. Lack of knowledge about location, eligibility and resources represented greater barriers for WCBA than for other PLWH/A. This is particularly relevant to their popularities, as they generally have more benefit programs available and open to them. Close to three quarters of the WCBA report "not knowing the location of the service providers" as a big problem for them, representing a moderate to big barrier.

Table 1-21 Reasons for Not Seeking Care

REASON	% with Problem	Average Score 5=very big 1=very small
Denial	82.5%	3.2
Not knowing location of the service(s)	73.7%	3.4
Not knowing that a service or treatment was available to me	70.2%	3.4
Not knowing who to ask for help	70.2%	2.9
Sensitivity to my issues and concerns	70.2%	3.0
Red tape	70.2%	3.3

Youth (13-24 Years Of Age)

The demographic profile of youth living with HIV/AIDS between 13-24 years of age receiving CARE Act-funded services is created with the review of two databases: OAPP Service Utilization Data (N=244) and the APLA Study (N=11). Each one contributes information about the population using different approaches and methodologies. The following section highlights the findings from the various data.

- According to the OAPP service utilization data, 26% of youth PLWH/A live in South SPA, 24% in South Bay-Long Beach SPA, 20% in Metro SPA, and 11% in San Fernando Valley SPA.
- According to the OAPP Client database, 51% identify as male, 45% as female and 4% as transgender.
- In the OAPP service utilization data, 45% are Latino, 40% are African American, 10% are Anglo, and 3% are Asian / Pacific Islanders.
- More than half (55%) of the youth in the APLA study identify as homosexual, and 45% identify as heterosexual. These figures match gender ratio of the population indicating that most male youth are MSM (which mirrored in OAPP service utilization data by fewer than 1% reporting IDU as the mode of HIV transmission).
- In the APLA study, 64% are single and 18% are partnered.
- Eighteen percent (18%) of the youth have not graduated from high school, 18% have received their high school diploma, and 64% have had some college education or higher.
- According to the APLA, 27% have no income, 64% make $25,500 or less, and 9% make $25,501-$34,000. Based on the OAPP service utilization data, 98% are within the typical criteria for CARE Act eligibility (three times the federal poverty level).
- In the APLA study, 18% of the youth have a history of being incarcerated—although it was not indicated how many of the incarceration problems were related to emancipation issues.
- According to OAPP service utilization data, 42% of the youth living with HIV/AIDS currently do not have any health insurance. This is high compared to the 20% in the APLA study who report not having health insurance.
- Those with health insurance, according to the APLA study, 44% have MediCal, 38% have Medicare, and 20% have private insurance or an HMO plan.

<u>Stage of Infection</u>

- The APLA study reports 22% of the youth have been living with HIV for less than a year, 44% for one to three years, 22% for three to eight years, and 11% have been living with HIV for more than eight years.
- According to the APLA study, none of the youth participants have been diagnosed with AIDS. Nearly three-quarters (73%) are asymptomatic and 27% are symptomatic.
- The youth in the APLA study report good (64%) to excellent (36%) health. Forty-six percent (46%) are doing the same as a year ago, and 55% are doing better.

Medication Adherence

In the APLA study, 44% of the youth are currently prescribed medications. Half of those currently on a regimen (23%) say no side effects have bothered them in the past six months compared to 33% saying they having been bothered "a little bit" and 17% being bothered "terribly."

Co-Morbidities

In the OAPP service utilization data, less than one percent of the population feel they contracted HIV through their injection drug use history. According to the APLA study, 9% have injected substances in the last six months. Ten percent (10%) have used crack, 10% have used cocaine, and 20% have used crystal, speed and/or uppers. The APLA study also reports that 10% of the youth have used marijuana, poppers and ecstasy in the past six months.

According to the APLA study, 9% have been homeless in the last six months, and 20% feel they are at risk of being homeless in the next three months.

Injection Drug Users

The profile of IDUs is derived from several sources of data: the SHAS, APLA client survey, the OAPP Client Database, and the 2002 NA Survey data.

The surveillance report indicates that by the end of 2001, about 13% of the living AIDS cases in Los Angeles County, are attributable to injection drug use. While this is a lower percentage than the national rate of about 20%, injection drug using PLWH/A in Los Angeles County, as in other EMAs face different barriers than other PLWH/A and present specific service needs.

Table 1-22 shows a comparison of the gender, age, racial/ethnic, risk group and geographic distribution for IDUs as presented in each dataset. First, it must be noted that the sample size for each of the data sets is very different. Also, recruitment and selection bias is inherent in each of the data sources. SHAS data reflects only PLWA. APLA data is also limited in that it only reflects PLWH/A who have accessed services at APLA and who report injection drug use within the past six months. Nonetheless, Table 1-22 indicates that:

- IDUs are predominantly men, ranging from 77% to 96% of all IDUs living with HIV/AIDS.
- Over 80% of IDUs are between the ages of 30 and 49.
- The four data sources show different ethnic/racial distributions. However, the OAPP Client data base and SHAS, perhaps the more representative samples, show that about one third of the IDUs are African American. This is consistent with the HARS data that shows that 32% of the PLWA at the end of 2001 are African American.
- Similar to the racial breakdown, the APLA and 2002 NA Survey data show strong sampling bias toward MSM/IDU. According to the HARS data, MSM account for about 42% of the IDUs. This is comparable to the percents found in both the OAPP Client Database and SHAS datasets.

- All data sources confirm that the largest proportion of the IDUs living with HIV and AIDS live in the Metro SPA. The second largest concentration of IDUs are found in South Bay SPA–Long Beach.

Table 1-22 IDU PLWH/A: Demographic Profile

		OAPP Service Utilization Data		SHAS		APLA		2002 Needs Assessment	
GENDER		**N=1268**	**%**	**N=114**	**%**	**N=66**	**%**	**N=65**	**%**
	Male	972	76.7%	96	84.2%	63	95.5%	56	86.2%
	Female	273	21.5%	18	15.8%	0	0.0%	8	12.3%
	Transgender	22	1.7%	0	0.0%	3	4.5%	1	1.5%
AGE GROUP									
	13-24	27	2.2%	NA		1	1.5%	1	1.6%
	25 – 29	49	3.9%	NA		3	4.5%	0	0.0%
	30-39	478	38.2%	NA		30	45.5%	16	25.0%
	40-49	525	42.0%	NA		26	39.4%	37	57.8%
	50 – 59	171	13.7%	NA		5	7.6%	10	15.6%
	60+	27	2.2%	NA		1	1.5%	0	0.0%
RACE/ETHNICITY									
	African Am	409	32.6%	42	36.8%	6	9.1%	12	18.8%
	Anglo	486	38.7%	21	18.4%	37	56.1%	33	51.6%
	API	15	1.2%	1	0.9%	1	1.5%	2	3.1%
	Latino	298	23.7%	44	38.6%	14	21.2%	11	17.2%
	Native Am	12	1.0%	2	1.8%	2	3.0%	3	4.7%
	Other	36	2.9%	4	3.5%	6	9.1%	3	4.7%
MODE									
	MSM	494	39.0%	50	43.9%	61	92.4%	35	53.8%
	Heterosexual	774	61.0%	64	56.1%	5	7.6%	30	46.2%
SPA									
	Antelope Valley	29	2.4%	1	0.9%			1	1.5%
	San Fernando Valley	147	12.4%	10	9.1%	4	6.1%	13	20.0%
	San Gabriel Valley	123	10.4%	17	15.5%	0	0.0%	6	9.2%
	Metro	258	21.8%	37	33.6%	53	80.3%	21	32.3%
	West	39	3.3%	3	2.7%	4	6.1%	6	9.2%
	South	158	13.3%	27	24.5%	3	4.5%	4	6.2%
	East	69	5.8%	7	6.4%	1	1.5%	3	4.6%
	South Bay - LB	362	30.5%	8	7.3%	1	1.5%	11	16.9%

In addition, based on the OAPP service utilization data:

- Over 96% of the IDUs live within 300% of federal poverty level.
- Forty-four percent report having no form of insurance and among those with insurance over 60% report having MediCal/Medicaid coverage.
- Forty-two percent of the IDUs rely on public sites for their health care with an additional 22% relying on hospitals' outpatient system for their care.

Stage of Infection

Based on the OAPP Client Database, less than half of the IDUs (44%) have received an AIDS diagnosis. For an additional eight percent of the HIV positive IDUs, AIDS diagnosis is unknown.

Co-Morbidities

Over one quarter of the IDU PLWH/A have a history of homelessness and nearly half (48%) have a history of mental illness.

Given the high incidence of homelessness and mental health history, IDU PLWH/A are a high-risk population with multiple service needs that require further investigation.

As expected, they use more heroin and crystal meth than other PLWH/A. Over 15% have used heroin in the last 6 month and 34% have used crystal meth in the last 6 months.

Services

The top need for IDUs are taxi vouchers (73%), dental care (73%), nutritional education (70%), and outpatient medical care (70%). Their top barriers tend to be individual, like lack of knowledge (70%) or not knowing a location (70%). State of mind, not understanding, and not knowing who to ask for help are barriers noted by about a third of IDUs.

Focus group participants often say that the reason they are out of care is due to drugs. A sampling of comments convey the issues faced by IDUs.

Comments from community forum participants highlight some of the gaps in services and challenges faced by IDU PLWH/A. For instance, an IDU male from the South Bay -LB SPA talked about his emotional and psychological state of mind. He said, *"I waited before getting medical care because I was in denial. I couldn't believe that I had contracted HIV. I thought I was going to die right there. It took me about a year to come to grips with me knowing that I had this disease. Psychologically trying to deal with it. I learned it just before I turned 42. It was the last thing that I wanted to find out. I'm still re-evaluating everything. I'm learning how to deal with this on a daily basis. Dealing with this information is like learning how to walk again, knowing that I've got to use a rubber, knowing that I've got to abstain from sex. I've still got a drug addiction. It's a lot to deal with. Plus I've already got arthritis from football injuries and I'm having surgery on my knees. It's very hard but as I said I'm coming to grips with it. If it wasn't for family I think I would have just committed suicide. It's not about the support group, it's more about the family understanding."*

A SPA2 MSM/IDU diagnosed in 1985 also spoke about how he dealt with his HIV diagnosis. He said, *"I was just too busy doing drugs when I found out I was HIV positive. I don't think I got a viral load or T-cell count for the first time until about 2 years ago."*

A SPA4 Anglo MSM/IDU describes the difficulty and consequences of not adhering to his medication, *"I did not see a doctor for about eight months. It was actually after I had been diagnosed for about six months or so. I had already been on medications and things, but I started using street drugs. I went back to the same doctor with no grief from him. My numbers got up there, but I didn't get sick to the point that I needed to see the doctor. That's not the*

reason I went to the doctor. From not taking the medicine and being on the street drugs my numbers went haywire, but it wasn't for that reason."

For an Anglo IDU woman from SPA 5 adhering to her medication while on crystal meth was very difficult. She said, *"I just wanted to say I used to like meth and I did do it while getting treatment. But I found that it made me more sick and it messed with my memory. I had a hard time remembering things so I eventually stopped and have just maintained it. I'm pregnant so I have to keep it up, but I did enjoy it. The downside of it was memory. It's like I would go backwards. I'd be taking my medicine and I would go forward and every time I messed up and played around with it recreationally it just set me back so f*ar."

Participants elaborate on the need for mental health services. A SPA5 Anglo MSM/IDU speaks of his situation, *"I have been going once a week to see a therapist for the last nine months. I've missed some times because I've been high and I'm really too high to come in. It was maybe a six-week period between the time I requested it and the time it started, but that doesn't seem like a real long time to me. It has really been really great and gracious. She's been able to also start a group on Tuesday nights which I started two weeks ago."*

Latinos, and more so monolingual Spanish speaking IDU, face greater challenges in trying to access mental health services. A SPA7 Latino IDU male said his depression was preventing him from seeing a doctor on a regular basis. He said, *"I got very depressed and tried to commit suicide. I used to flush the medicines in the toilette and I did not want to see the doctor. I wanted more information from my doctor to find out how to get over my depression. There are no support groups for Latino men in Spanish. There are no therapists for men. It does not exist. It only exists for women."*

Participants also speak of the basic needs of food and shelter. A SPA5 Anglo IDU male said, *"Food vouchers would be nice. Because I'm homeless, I don't have a place to put my food that I get from the food pantry. Food vouchers are like cash. They're great. I could use those. I can eat out with those. I can buy what I need and not have to have all of this stuff."*

A SPA4 Anglo MSM/IDU said, *"I take advantage of the food pantry but I use the food too. I go home and I cook the food. That's what I eat. Those are my meals. I was offered [the meal program] and I didn't take advantage of it for the simple fact that I'm able to cook my own food. So I go to the food bank and I pick up food that I can take home and cook it myself. I think [the meal program] is more for the people who are not able to cook their food, because it's something that is already cooked up and made for them. As far as vitamins and the Boost, I've never seen vitamins offered because I would take advantage of that if it was offered."*

Non-IDU Drug Users

Non IDU drug users (NIDU) are a combination of those who do not inject opiates and/or those who use "party drugs" such as GHB, poppers and/or ecstasy. While speed and crystal meth can be injected, the most common use is freebees or snorting, and, like injection, these can lead to addictions.

The concern about non-IDU drugs is that they impede judgment and those using them are more likely to engage in risky behavior, plus they may interfere with the prescribed medications. It is common for NIDU to use several various forms of drugs over the course of six months.

- The most common and highest drug use among this population is marijuana, with about 30% using it weekly. According to the APLA survey, 13% of the participants said they used crystal or speed in the last month. The 2000 Needs Assessment Survey reports 8% using crystal meth or speed in the last month. Users were more likely to be homeless, severely mentally ill and/or recently incarcerated.
- GHB, poppers and ecstasy are used more by Anglo MSM and IDUs. There is slightly higher use among the recently incarcerated.

NIDU are more likely than the general PLWH/A population to be:

- Male;
- African American;
- Bisexual;
- Under-educated;
- Living with others; and
- Not looking for work.

Stage of Infection

Non-injection drug users are less likely to have an AIDS diagnosis and are more likely to have been infected recently. They are more likely to report feeling worse both physically and emotionally than other PLWH/A, which, in part, is probably due to ongoing substance use.

Co-Morbidities

While more likely to use non-injection drugs than most PLWH/A, non-injection drug users are less likely to report STDs, particularly hepatitis. They are less likely than the general population of PLWH/A to report homelessness or have had a history in transitional housing. Non-injection drug users are more likely to seek and take medication for mental illnesses.

Adherence

One of the strongest arguments that non-injection drug use has detrimental impact on PLWH/A is that they are considerably less likely to adhere to their drug regimen than other PLWH/A. About 37% report skipping their medication at least weekly. However, fewer have stopped medication altogether compared to the total sample of PLWH/A. Over 40% say they forget to take their medication.

Top Services

About three-quarters of non-injection drug users say that food pantry, outpatient medical care, taxi vouchers and case management are their top needs. These expressed needs tend to be higher than the general populations of PLWH/A, particularly taxi and food vouchers. In the 2002 focus forums, much of their response on this was focused on asking for housing, taxi vouchers, and counseling services than other PLWH/A.

Top Barriers

Their top barriers parallel those of the general population of PLWH/A. They are, however, more likely to say transportation, waiting time and not understanding who to go to for help are barriers to care.

Homeless

The demographic profile of the homeless in the continuum of care is created with the review of four databases. Each one contributes information about the community using different approaches and methodologies. There are 1,850 who say they have a history of homelessness in the OAPP service utilization data. The APLA (N=76) study is based on being homeless in the last six months. The SHAS (N=51) sample is based on homelessness at the time of consumer's participation and only includes PLWA. The 2002 Needs Assessment Survey (N=48) is based on a history of being homeless in the last two years. The following section highlights the findings from the various data.

- According to the OAPP service utilization data, 36% of the homeless PLWH/A live in the Metro SPA, 22% in South Bay-Long Beach SPA, and 15% in South SPA. Less than 19% of the Anglo MSM live in the other five SPAs.
- In OAPP service utilization data, 78% identify as male, 20% as female and 2% as transgender. The APLA study is likely to have oversampled transgenders with 5% of homeless PLWH/A reporting transgender, 16% identifying as female, and 79% as male.
- The mean age of homeless PLWH/A is 40 (2002 Needs Assessment Survey). Youth (13 to 24 years old) make up 7%, those between the ages of 25 and 54 years make up 89% and those 55 years or older make up 3% of the population (OAPP service utilization data).
- According to OAPP service utilization data, those with a history of being homeless are 39% African American, 30% Anglo, 27% Latino, and about one percent each of Asian and Native American.
- According to OAPP service utilization data, 42% feel they contracted HIV by male-to-male sex, 21% from heterosexual sex, and 19% by injection drug usage.
- From the 2002 Needs Assessment Survey, 25% did not graduate from high school, 35% have a high school diploma as their highest level of education, and 40% have some college education or higher.
- According to the 2002 Needs Assessment Survey, 44% of those who have been homeless in the last two months are currently living in an apartment/house they own or rent. Nearly a third (32%) are currently in transitional housing (e.g. "crashing" with someone without paying rent, a single resident occupancy, or a half-way house). Three percent (3%) are currently homeless on the street or in a shelter. Though 92% say their living situation is safe

and habitable, 13% say the living situation is not stable. In the APLA study, 49% of homeless PLWH/A say they are at risk of being homeless in next three months.

- According to the 2002 Needs Assessment Survey, 17% of homeless PLWH/A are employed either part or full-time, 33% are not working, but are looking for work and 6% are retired. In the SHAS study, 18% of homeless PLWA are currently employed.
- All surveys show that the homeless are among the poorest PLWH/A.
- More than half (52%) of homeless PLWH/A have been incarcerated in the last two years (2002 Needs Assessment Survey). In the APLA study (PLWH/A) and the SHAS study (PLWA), about 52% have been arrested or spent time in jail, detention or prison for longer than 24 hours at some point in their life.
- The 2002 Needs Assessment Survey reports 40% are receiving food stamps, 27% receive SSI, 15% receive SSDI, and 27% are receiving General Assistance.
- According to OAPP service utilization data and the 2002 Needs Assessment Survey, 50% of the homeless PLWH/A currently do not have any health insurance. This is high compared to 37% in the APLA study. The SHAS study reports 72% of the homeless PLWA do not have health insurance.

Stage of Infection

- Homeless PLWH/A are newer to the HIV/AIDS community. The 2002 Needs Assessment Survey shows 13% of homeless PLWH/A have had HIV for less than a year (compared to 5% of the general PLWH/A) and 17% have been positive between one to three years.
- According to the 2002 Needs Assessment Survey, 55% of the homeless PLWH/A report disabling symptoms. A third report (33%) having received an AIDS diagnosis--comparable to APLA's study showing 37% with an AIDS diagnosis. Half of the homeless (50%) have been living with AIDS for less than 3 years.
- According to the 2002 Needs Assessment Survey, 56% of the homeless PLWH/A report having better physical health now than when they first sought treatment for their HIV, compared to 61% of all PLWH/A. About two-thirds (62%) are more likely to say they currently have good to excellent physical health.

Medication Adherence

Based on the 2002 Needs Assessment Survey, 59% of homeless PLWH/A have a history of taking antiretrovirals or protease inhibitors compared to 62% of all PLWH/A. Nearly a quarter (23%) have stopped taking their medicine, and 52% report having skipped their medications at least monthly. The primary reasons for skipping their medications were because they forgot (46%), they did not wanting to take them (29%), because they were homeless at the time (27%) and side effects (19%). According to the SHAS data, 96% of homeless PLWA have a history of taking antiretroviral medications. About 43% of the sample were not able to take the HIV/AIDS medicines exactly the way their doctor told them to. Reasons for missing their doses include: "I sold them so I could get money"; side effects; and/or "I often forget to take them."

In the APLA study, nearly three-quarters (73%) of the homeless PLWH/A are currently prescribed medications. Alarmingly, 73% of those on medications report experiencing side effects that have bothered them.

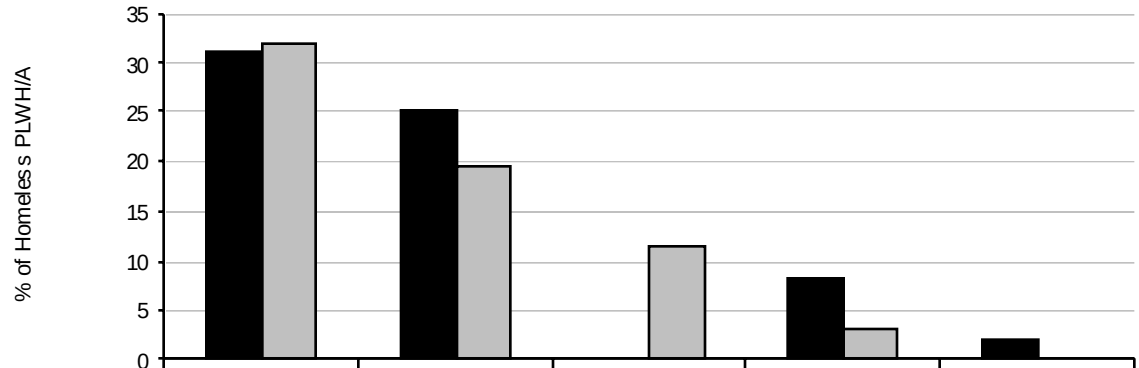
Co-Morbidities

According to SHAS data, 29% of the homeless PLWA have tested positive for TB skin, compared to 16% of the general PLWH/A. Six percent (6%) report having active TB.

In the 2002 Needs Assessment Survey, 25% of the homeless PLWH/A have been diagnosed with hepatitis A, B or C in the last two years. Seventeen percent (17%) have had yeast infections, and 10% have had syphilis or chlamydia in the last two years. Four percent (4%) of the homeless report having been diagnosed with gonorrhea in the last two years.

From the OAPP service utilization data, 19% of the homeless feel they contracted HIV through their injection drug use history. According to the 2002 Needs Assessment Survey, 44% of the homeless PLWH/A report a history of injection drug use, compared to 23% of the total PLWH/A sample. Seventeen percent (17%) of the homeless PLWH/A in the APLA study say they have injected in the last six months, compared to 5% of the general PLWH/A. Figure 1-47shows the usage of injectable substances in the last six months as reported in the 2002 Needs Assessment Survey and the APLA study. Crystal meth has the highest usage with about 31% of both the 2002 Needs Assessment Survey and APLA samples reporting its use. Crack is also used frequently by 25% of the 2002 Needs Assessment Survey sample and 19% of the APLA sample.

Figure 1-47 Injectable Substance Usage in Last Six Months



	Crystal Meth	Crack	Cocaine	Heroin	Speed
2002 Survey	31.3	25.0		8.3	2.1
APLA	31.9	19.4	11.6	2.9	

The 2002 Needs Assessment Survey also reports that nearly half of the homeless PLWH/A (46%) have consumed alcohol within the last six months with 10% drinking once a week or more. Thirty-eight percent (38%) of the sample have used marijuana in the last six months, with 17% smoking it once a week or more.

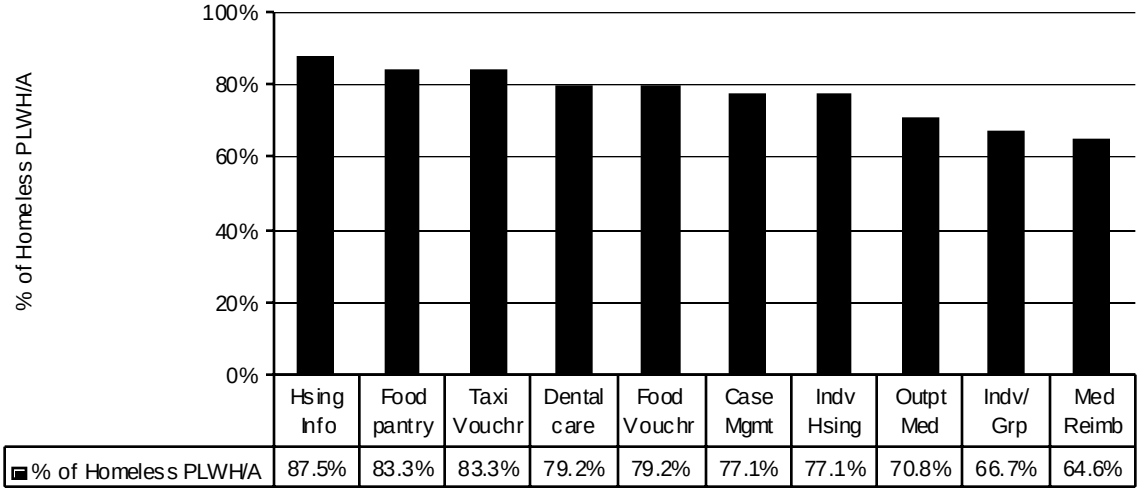
Fifty-six percent (56%) of the homeless have received mental health services since they were diagnosed with HIV. Thirteen percent (13%) have been an inpatient for mental health services,

42% have participated in group counseling or therapy with a professional, and 50% have had individual counseling or therapy with a professional. In the last two years, 50% have received a depression diagnosis and 34% have received an anxiety diagnosis. These services may be successful due to 56% of the homeless PLWH/A reporting good to excellent emotional health and 65% report doing better emotionally today than when they first sought treatment for their HIV.

Top Service Need

Based on the 2002 Needs Assessment Survey, Figure 1-48 shows the top ten service needs for the homeless PLWH/A which includes three housing services: housing information services (88%) and independent housing (77%). Other top needs include the food pantry (83%), taxi vouchers (83%), dental care (79%) and food vouchers (79%). Given their other basic need, outpatient medical care is not in the top five needed services but is instead ranked eighth, with 71% expressing the need for the service, compared to 79% of the general PLWH/A.

Figure 1-48 Top Service Needs for Homeless PLWH/A



Barriers

Using a five point scale where "1" indicates a very small problem in seeking care and a "5" represents a big problem, participants were asked to rate 30 items in terms of the level of difficulty they represented for them when trying to access care. Table 1-23 shows the top five reasons along with the average score indicating the size of the barrier each of the items represented for them.

The top five barriers for homeless PLWH/A are individual barriers. Compared to the general PLWH/A sample, those with a history of being homeless in the last two years report having more problems in getting services and they give those problems higher difficulty ratings. The largest problem experienced by 82% of the respondents is denial that HIV/AIDS is a problem that requires assistance. This may be linked to a high percentage of PLWH/A continuing drug usage while homeless.

Table 1-23 Barriers to Care

REASON	% with Problem	Average Score 5=very big 1=very small
Not believing HIV/AIDS is a problem that requires assistance	81.3	3.0
Not knowing service or treatment was available to me	79.2	3.5
Not knowing who to ask for help	79.2	3.2
The state of mind or mental ability to deal with treatment	77.1	3.5
Not knowing location of the services	75.0	2.8

Severely Mentally Ill

More and more research is demonstrating how mental illness can affect the course of HIV disease, such as its effects on medication adherence and how it may affect the likelihood that people will engage in high-risk behaviors that could transmit the disease. Psychiatric problems are common in HIV-infected patients and studies have shown that although these problems may occur as a response to HIV infection, in many cases they are longstanding and can potentially have contributed to the high-risk behaviors which led to HIV infection.

Demographic Profile

In this report, the severely mentally ill (SMI) are defined as PLWH/A with a history of inpatient mental health treatment, or with a diagnosis of anxiety, dementia, depression or bipolar disease, or who have received medication for psychological or behavioral problems. Using this definition, 81 severely mentally ill PLWH/A completed the 2002 Needs Assessment Survey. Nineteen percent (19%) of the clients in the OAPP service utilization data report a history of mental illness. However, the item used to capture mental health history is "Does the client have a self-reported and/or documented history of mental health conditions," and is too broad to use as a comparison to the severely mental ill as defined above.

Table 1-24 presents the gender, age, racial/ethnic, risk group and geographic distribution for the SMI living with HIV/AIDS who completed the 2002 Needs Assessment Survey, compared to all PLWH/A in Los Angeles County. It indicates that:

- More than three-quarters of the SMI are men, but women living with HIV/AIDS are disproportionately affected by mental illness.
- SMI living with HIV/AIDS tend to be older than other PLWH/A, with more than 48% being 45 years of age or older.
- While Anglo PLWH/A represent about 20% of all PLWH/A, they represent about 35% of the SMI. On the other hand, Latinos account for more than half of the PLWH/A, yet they account for about one quarter of the SMI. African Americans also account for about one quarter of the SMI. The lower rate among the communities of color may reflect an actual lower prevalence of mental illness among these communities, but it could also reflect a lower level of access to mental health providers resulting a lower rate of diagnosis and/or a higher cultural stigma or reduced cultural acceptance of mental illness in these communities.

- With a large proportion of the SMI (40%) also having a history of injection drug use, this dually affected population is a need of specialized services to address both their mental health as well as substance use needs.
- The largest proportion of the SMI live in the Metro SPA (35%), followed by the South Bay–Long Beach SPA.

Table 1-24 Severely Mentally Ill PLWH/A: Demographic Profile

		2002 NA		% PLWH/A
GENDER		N=81	%	
	Male	62	76.5%	87.2%
	Female	17	21.0%	12.8%
	Transgender	2	2.5%	
AGE GROUP				
	<13	0	0.0%	0.6%
	13 -19	0	0.0%	2.1%
	20-44	40	51.9%	83.1%
	45+	37	48.1%	14.3%
RACE/ETHNICITY				
	Af Am	22	27.5%	29.9%
	Anglo	28	35.0%	29.1%
	API	4	5.0%	3.0%
	Latino	22	27.5%	45.0%
	Native Am	1	1.3%	0.9%
	Other	3	3.8%	1.2%
MODE				
	MSM	35	43.2%	68.3%
	MSMIDU	20	24.7%	10.7%
	IDU	12	14.8%	6.2%
	Hetero	14	17.3%	13.6%
SPA				
	Antelope Valley	1	1.2%	
	San Fernando Valley	10	12.3%	
	San Gabriel Valley	6	7.4%	
	Metro	28	34.6%	
	West	6	7.4%	
	South	11	13.6%	
	East	4	4.9%	
	South Bay - LB	15	18.5%	

In addition, not shown in the table:

- More than half (53%) of the SMI have less than a high school education, and about 18% are employed in some capacity.
- Comparable to other PLWH/A, SMI living with HIV/AIDS are likely to live in poverty, with over half (53%) reporting an annual income of less than $8,600, and 97% being within 300% of federal poverty level.
- The majority of SMI live alone, yet 20% have children.
- Perhaps due to their dual diagnosis, SMI (82%) are much more likely than other PLWH/A (72%) to have health insurance, with 62% having MediCal/Medicaid and 36% having Medicare coverage (probably due, in part, to the older nature of the population).

Stage of Infection

Not surprisingly, SMI are more likely than other PLWH/A to have been told their infection has progressed to AIDS, and are also more likely to have lived with HIV for longer than 12 years. The longer length of time dealing with the infection may account for the higher rates of depression and the greater need for mental health treatment. Close to 70% of the SMI report experiencing disabling symptoms associated with their HIV, and about 62% have had CD4 counts below 200.

Table 1-25 Length of HIV Infection

	Number	Percent (%)
Less than 3 years	10	13.3
3 to 6 years	9	12.0
6 to 12 years	28	37.3
More than 12 years	28	37.3
Total	75	100.0%

SMI report similar physical health status as all PLWH/A, with about half reporting good to excellent health. However, as expected, SMI (15%) are more likely than all PLWH/A (10%) to report poor emotional health. On a positive note, SMI do report improvement in both their physical and emotional health since first seeking treatment.

Medication Adherence

SMI (69%) are slightly more likely than all PLWH/A (67%) to currently be taking medicines for their HIV infection. They are also more likely to face difficulties adhering to their medications. Fewer than one third of the SMI report taking their medication as prescribed by their doctor and 13% have stopped taking medication all together.

Table 1-26 shows the top five reasons that the SMI cited for not taking their medications as prescribed. SMI, like all PLWH/A, report forgetting to take the medications as the first reason for not adhering to the medication regimen. Not wanting to take medications and "side effects" were the second and third most prevalent reasons for their non-adherence.

Table 1-26 Top Reasons for Skipping Medications

Top Reasons	N=	Percent
Forgot	36	44.4%
Just did not want to take them	22	27.2%
Side effects	20	24.7%
Difficult schedule	14	17.3%
Hard to coordinate with food	14	17.3%

Co-Morbidities

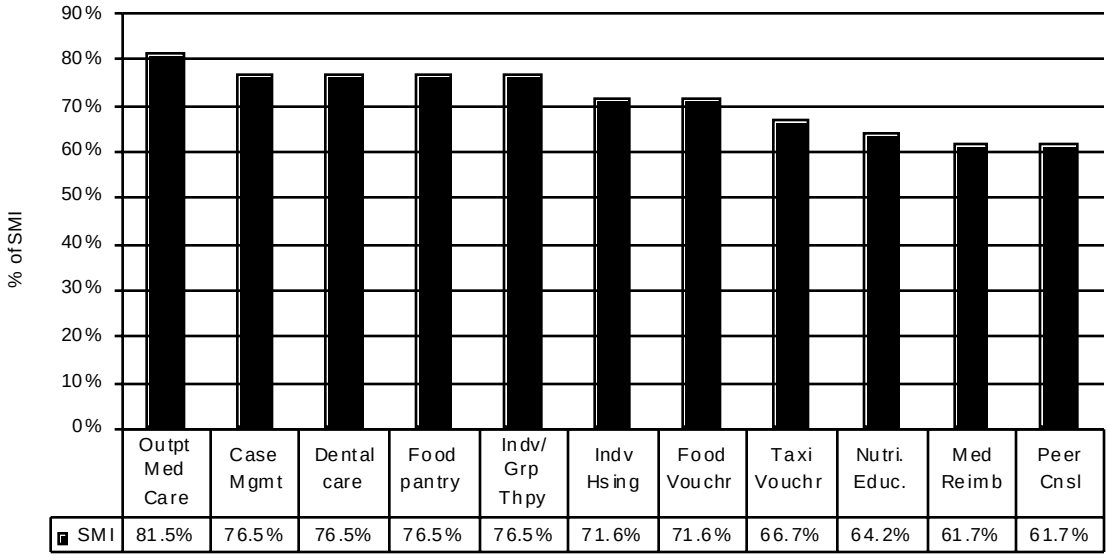
Twenty percent (20%) of the SMI have had hepatitis A or B, and almost one quarter have had hepatitis C. Thirty-two percent (32%) have had yeast infections, six have had genital warts, five have had chlamydia, and four have had syphilis.

As expected, SMI are likely to report higher substance use than other PLWH/A. Alcohol remains the most common substance used by SMI, followed by marijuana. More than one quarter (26%) of the SMI report using crystal meth, compared to 14% of other PLWH/A.

Top Service Need

Figure 1-49 shows the top service needs for the SMI based on the 2002 needs assessment. Overall, SMI report higher need for services than other PLWH/A. Yet, like all other populations, SMI ranked outpatient medical care as their number one need with dental care, food pantry services and case management also among their top needs. Not surprisingly, SMI report a greater need for mental health services, including peer counseling and individual/group therapy, than other PLWH/A.

Figure 1-49 Top Service Needs for SMI



Barriers

Overall, SMI tend to report experiencing greater barriers in accessing care than other PLWH/A in the sample. They rate 21 out of 30 items as a greater problem when accessing care than other PLWH/A. For instance, 73% of the SMI consider their own state of mind as a barrier to care compared to 65% of all other PLWH/A. Also, 57% of the SMI feel that not getting along with their provider is a problem, compared to 50% of other PLWH/A. The top barriers identified by the SMI are shown in Table 1-27 and range from small to big barriers.

Table 1-27 Barriers to Care

REASON	% with Problem	Average Score 5=very big 1=very small
Knowing treatments	77.8%	3.3
State of mind	72.8%	3.0
Waiting for an appointment	71.6%	2.7
Not knowing location	71.6%	2.7
Sensitivity of organization	70.4%	2.8

Transgender

The demographic profile of transgender persons (TG) living with HIV/AIDS is created based on data from three databases: OAPP Client Service Utilization Data Collection System (N=191), LA Transgender Health Study (N=54) and the APLA study (N=25). Each one contributes information about the community using different approaches and methodologies. The following section highlights the findings from the various data.

- According to the OAPP service utilization data, 49% of the TG living with HIV/AIDS live in the Metro SPA, 19% in South Bay SPA, and 15% in South SPA. In the APLA study, a larger percentage live in the Metro SPA (75%) and 15% live in the San Fernando Valley SPA.
- From the OAPP service utilization data, 17% are young (24 years or younger) and 83% are between the ages of 25 and 54 years old. The age group in the APLA sample is older, with 84% between the ages of 30 and 49 years old and 16% being 50 years old or older.
- Latinos are the largest ethnic group in each of the three studies. The ethnic breakdown of the OAPP service utilization data is 48% are Latino, 35% are African American, 10% are Anglo, 5% are API and about 3% is Native American or other. In the APLA study, two-thirds (67%) are Latino and 13% are African American. In the Transgender study, 60% are Latino, 14% are of other/mixed descent, African American and Anglo are both 12% and API are 4%.
- In the APLA study, 75% identify as gay, 15% as bisexual and 10% as straight. For purposes of TG analysis, gay refers to sex with men, although all TGs in the studies were male-to-female TGs.
- In the Transgender study, 61% of TG did not graduate from high school, 22% did graduate from school and 17% have some college education or higher. The APLA study showed towards higher educational levels, with 44% having some college education or higher and 9% reaching graduate level.
- According to the APLA study, 68% report being single, and 24% are either married or partnered.
- The APLA study shows that all TG participants make $17,000 or less in annual income before taxes with 36% with no income at all. The OAPP service utilization data reports 92% are living within the 300% poverty level necessary to meet the typical criteria for CARE Act eligibility. In the Transgender study, 69% report an income less than $12,000 and 31% greater than $31,000. The variances in income data may be related to the non-traditional sources of income (e.g., sex work) for a majority of TGs.

- Fifty-nine percent (59%) report they are using sex work as a main source of income.
- In the APLA study, 38% have a history of being incarcerated.
- According to OAPP service utilization data, 51% of the TG living with HIV/AIDS currently do not have any health insurance. Those that have health insurance tend to have MediCal (29%) and Medicare (21%).
- The OAPP service utilization data shows 41% of the TG going to a public health care provider, 33% going to a private provider and 13% receiving outpatient medical care.
- The OAPP service utilization data shows 45% of the TG believe they contracted HIV through male-to-male sex, 13% believe it was from injection drug usage, 15% believe it was through heterosexual sex, and 27% have unknown mode of transmission. Data was not collected, however, to determine what percentage of male-to-male and heterosexual transmission occurred before and after gender conversion, and specifically hoe respondents characterized their sexual activity/sexual orientation.

Stage of Infection

Stage of infection information is based on the APLA study which asked about HIV status, length of time living with HIV and current physical health. The APLA study showed that:

- Forty-four percent (44%) of TG have been living with HIV/AIDS for eight years or longer. Thirteen percent (13%) have known of their status for less than a year.
- Fourteen percent (14%) of TG have been diagnosed with AIDS. Of the other 86% of the sample, 36% are living with HIV without symptoms, and 50% with symptoms.
- More than two-thirds (67%) report having good to excellent general health. Forty-eight percent (48%) say they are doing about the same, and 44% say they are doing better than a year ago.

Medication Adherence

In the APLA study, 81% of the TGs living with HIV/AIDS are currently prescribed medications. Nearly a third of those currently on a medication regimen (29%) say that there have been no side effects that have bothered them in the past six months, compared to third (33%) who say side effects have bothered them "a lot" or "terribly." The issue of whether or not other medications they must take as TGs (e.g., hormonal therapies) may complicate or play a role in their experiences with side effects or their adherence behaviors was not explained, but will be in the future.

Co-Morbidities

As mentioned earlier, 13% of the TGs feel they contracted HIV through their injection drug use history. The APLA study inquires about substance usage in the last six months. Crystal meth has the highest usage amongst injectable drugs with 25% of the sample saying they have used it in the last six months. Fourteen percent (14%) say they use it once a month. Cocaine is a substance used by 11% of the population, with 6% saying they use it about once a month. More than two-thirds (65%) report using marijuana in the last six months, with

23% using it close to every day. Poppers are also used by 11% of the sample, with a frequency of once a month.

The APLA reports 16% of the TG have been homeless in the last six months, compared to 6% of the general population. Seventeen percent (17%) of the sample believe they are at risk to being homeless in the next three months.

Undocumented PLWH/A

California leads every state in the nation as a destination for undocumented immigrants. In 1996, the Immigration and Naturalization Service (INS) estimated that about 5 million undocumented immigrants were living in the United States, and the population was estimated to be growing by about 275,000 each year. According to these same estimates, almost half of the undocumented immigrant population in the United States (2 million) resides in California. However, the precise numbers, especially at the city or county level, remain hard to estimate, because undocumented immigrants are unlikely to reveal their immigration status. Furthermore, with the fear and stigma associated with HIV infection, especially among immigrant communities, accurate estimates of the current number of undocumented PLWH/A in the Los Angeles County.

Demographic Profile

- Eighteen (18) undocumented PLWH/A completed the 2002 Needs Assessment Survey: nine men, seven women and two transgender persons. Seventeen (17) out of the 18 undocumented PLWH/A were Latino; twelve Mexican, four Central American, one Asian, and one who did not indicate country of origin.
- Undocumented PLWH/A tend to be younger (mean age 35) than other PLWH/A (mean age 43), have less years of formal education (55% with less than high school), and despite having a higher rate of employment (39%), are more likely to have an annual income of less than $8,500 (79%). The low incomes and higher rates of employment are often due to work performed without legal status and without the benefits of minimum wages.
- Seventy-eight percent (78%) of the undocumented identify as heterosexuals, and the large majority live with other adults and/or children.
- Undocumented PLWH/A are more vulnerable to homelessness. Twenty-eight percent (28%) of the undocumented have been homeless in the past two years, compared to 20% among all PLWH/A. The undocumented are also less likely than other PLWH/A to feel that their current living situation is stable, secure or habitable. Only 55% of the undocumented PLWH/A feel that their current housing situation is stable, compared to 87% of all PLWH/A.
- Eight out of the 18 undocumented PLWH/A live in the Metro SPA, six live in the South SPA, and one each in four other SPAs. None of the undocumented report living in Antelope Valley, nor the San Gabriel Valley SPAs.
- Not surprising, the majority of the undocumented PLWH/A (67%) are uninsured, with only four reporting MediCal/Medicaid coverage.

Stage of Infection

About one-third of the undocumented PLWH/A have known their HIV status for less than three years, yet half have already being diagnosed with AIDS. Currently, 56% report being asymptomatic, 50% feel that their physical health is good to excellent, and 80% report an improvement in their health since when they first sought treatment. Emotionally, undocumented PLWH/A report a tenacious spirit with more than 70% reporting a good to excellent emotional status, and over 80% reporting an improvement in their emotional health, since they first sought treatment.

Medication Adherence

Undocumented PLWH/A are slightly less likely to be taking medicines for their HIV infection compared to all PLWH/A (62%), and they are also less likely to adhere to their medication regimens. Similar to other PLWH/A, forgetting is the top reason for not taking the medication as prescribed. Undocumented PLWH/A also report side effects and the difficulty of coordinating medicines with food as top reasons for not taking the medicines. The undocumented are more likely than other PLWH/A to feel that they no longer need the medication.

Co-Morbidities

With the limited sample of participants, no generalizations can be made. However, undocumented PLWH/A show a pattern of higher rate of STDs than other PLWH/A: six out of 18 undocumented PLWH/A have had hepatitis A or B, and two report having had hepatitis C. Additionally, two have had syphilis, genital warts and yeast infections.

Substance use is relatively low amongst undocumented PLWH/A, and much lower than amongst all PLWH/A. Four undocumented reported alcohol use, one reported using marijuana, crack and/or crystal meth. Also, one reported injection drug use.

Top Service Need

Table 1-28 shows that the undocumented express greater need for services that support daily living including food vouchers, DEFA and transportation. Outpatient care drops from first among all PLWH/A to second among the undocumented. While undocumented PLWH/A report a greater need than all PLWH/A for housing information services, they report a lower need for individual housing.

Table 1-28 Top Service Needs - Undocumented PLWH/A

SERVICE CATEGORY	UNDOCUMENTED PLWH/A RANK	TOTAL PLWH/A RANK
Food Voucher	1	7
Outpatient Medical Care	2	1
DEFA	3	
Food pantry	4	2
Housing Information Service	5	10
Individual Housing	6	6
Van Transportation	7	
Dental care	8	3
Case Management	9	4
Taxi Voucher	10	5
Peer Counseling	11	9
Medical Specialist	12	
Medical Case Management	13	
Nutrition Education	14	8
Individual/ Group Therapy	15	

Barriers

On average, the undocumented report similar barriers than all PLWH/A, with a mean barrier score of 2.7, indicating small to moderate barriers. However, undocumented PLWH/A tend to face a greater number of barriers overall in their daily lives, and report a greater number of structural barriers as opposed to organizational or individual barriers. For instance, as shown in Table 1-27, among the top barriers faced by undocumented PLWH/A are not being eligible for services, red tape and lack of insurance. Considering their undocumented status, these barriers are not unusual and while they represent a problem in accessing care, on average, the undocumented PLWH/A actually feel that their own lack of knowledge and denial about their infection represent greater barriers.

Table 1-29 Barriers to Care

REASON	% with Problem	Average Score 5=very big 1=very small
Not eligible	77.8%	2.6
Knowing treatments	72.2%	3.2
Denial	72.2%	3.3
Not knowing location	72.2%	2.7
Red tape	72.2%	2.6
No transportation	72.2%	2.7
Lack of insurance	72.2%	2.4

In a community forum held in the East SPA, a Latino MSM who volunteers at a service agency described how the lack of information imparted to the undocumented PLWH/A results in under-utilized services: *"I believe there is a lack of information given by the agencies. There are apartments and housing available. All this is being given to this association so that people can live. The lack of information does not allow the people to go where they have to go. I just recommended a person from El Salvador who does not have papers and he just received housing. The confusion is that there are people who have*

received a certificate or voucher, but they have looked for housing themselves. They did not take advantage of the opportunities that the City gave them. Organizations like the one I volunteer for are grabbing the funds and they are giving certificates to the people that need housing. Therefore they help people with or without documents, whether new applicants or old, they all have the same rights."

2. WHERE ARE WE GOING?

The Los Angeles County's Commission on HIV Health Services has developed several planning initiatives in 2001 and 2002 resulting in an ambitious agenda for sustaining and improving services for PLWH/A, even as the public health system in Los Angeles County is facing a fiscal crisis that will reduce publicly funded health care services. They include:

- Within the next three years there is a commitment by the Office of AIDS Programs and Policy (OAPP), the Commission on HIV Health Services (CHHS), and the Prevention Planning Committee (PPC) to move toward an integrated prevention and care services continuum of service, and using a web-enabled data collection and tracking system to support that effort.
- With the implementation of HIV reporting statewide, the Los Angeles County's HIV Epidemiology Program will be able to more accurately track and describe the epidemic. Once a person tested HIV+, a system will be implemented to encourage those in care to seek care and stay in care.
- HIV reporting and the active follow-up of those testing HIV+ is likely to significantly reduce the number of PLWH who are not in care and allow better coordinated care for individuals in the system.
- Further development and implementation of standards of care, quality assurance, outcomes and indicators for services will increasingly play an integral role in the monitoring process.
- The Commission will separate from OAPP oversight, and, in so doing, will engage its own professional support staff to carry out its responsibilities.
- The Commission will undertake a more comprehensive ongoing needs assessment process by adopting a continuous data collection model that utilizes ongoing data collection tools, as well as specialized needs assessment studies where data is lacking and further research needed.
- Service planning will be done at the SPA and potentially at the sub-SPA neighborhood level in order to reflect the different needs of communities throughout Los Angeles County. Service Provider Networks (SPN)–see Attachment 14--and the Coordinated Prevention Networks (CPNs) (as described in the Prevention HIV Prevention Cooperative Agreement for 2002) will lead these efforts with support from OAPP and the Commission.

METHODOLOGY

To better codify the changes in this section of the Plan, Partnerships for Community Health:

- Reviewed planning documents (see Bibliography, Attachment 2);
- Led several workshops with the Commission's Priorities and Planning (P&P) Committee where tools were developed focusing on system-wide, service delivery, and administrative objectives;
- Surveyed (via questionnaire) (see companion Methodology Report) all members of the Commission and 102 contract agencies. The seven-page document was primarily

focused on the following objectives: shared vision, shared values, core strengths and weaknesses and service objectives. Commissioners and agency representatives submitted their feedback to the P&P Committee, which completed it with other information for the Plan.

CONCEPTUAL FRAMEWORK

Conceptually the objectives for the next three years are grouped under three categories:

- Program Support that will enhance overall quality of care in the EMA by building, supporting and improving organizational capacity and provider capabilities.
- Commission Support will provide the Commission with full time professional staff to help it perform its financial, planning and evaluation obligations.
- Service Delivery objectives designed to meet service needs, overcome gaps, and address needed capacity. They are further divided into objectives that address the services specified in the continuum of care: 1) primary health care core, 2) removal of barriers, 3) patient care coordination, 4) economic well-being and 5) enhancement services.

CORE COMPETENCIES & WEAKNESSES OF Los Angeles County HIV/AIDS CARE SYSTEM

The core competencies and weakness following are based on feedback from Commissioners, providers and consumers. The response rate to the survey of commissioners and providers was relatively low, and, consequently, the items in each list may not represent a consensus of the Commission nor have they been independently verified. Nevertheless, they do parallel many of the competencies and weaknesses stated in key informant and focus forum interviews. The P&P Committee is planning a widespread community forum process in the winter 2002-2003, to more actively engage consumer and community participation and more comprehensively elicit feedback and perspective on care competencies and weaknesses (among other elements of the Plan).

In many instances the lists generated by Commissioner/provider and consumer input parallel each other. The competencies reference recent improvements in the planning process, communication of the Commission and the interface with OAPP. It references recent work done on the continuum of care, standards of care and training.

The weaknesses indicate that there is still significant ground to cover before the Commission truly owns the planning process. In addition, there is a continued need to integrate services between and among CARE Act-funded and non-CARE Act-funded providers, such as housing and substance abuse providers.

Table 2-1 Competencies of the HIV Care System*

Program Support / OAPP

1. OAPP has stepped in and helped our agency at the administration level. OAPP taught us better ways to do our monthly reports.
2. Helpful program monitors.
3. OAPP has a good staff: each audit at our homes has been helpful to our agency.
4. OAPP training courses have been very helpful.
5. Increased collaboration with AIDS service providers and case workers.
6. The willingness to work close with us on the front lines.
7. Communicating effectively and soliciting input from all stakeholders, particularly clients.
8. OAPP and Commission commitment to working collaboratively with CBOs.
9. Increased exchange of information and services between caseworkers, AIDS service providers, and other services.
10. Overall service delivery/implementation.
11. Good collaboration with provider network.
12. Improving provider network data collection.
13. Lines of communication between agencies.
14. The great response to questions forwarded to them.

Commission

15. Strong vision and strong leadership.
16. Good specification of continuum of care.
17. Planning is more comprehensive and focused.
18. Commission is representative of Los Angeles demographic populations.
19. Allocating resources; setting policy.
20. The ability to make additional funding available to programs.
21. Developing processes which are fair and impartial in setting priorities
22. Building broad-based support and commitment to the mission.
23. Financial reporting and access to financial reporting by the Commission is very good and a model for other entities like HOPWA.
24. Commitment to age-appropriate care.
25. Steady funding.

Service Delivery & Providers

26. County services are equal to and in some cases better than private delivery networks.
27. Development of counseling and housing services with other social service continuums.
28. Larger agencies provide service support (i.e. housing) to the smaller ASOs.
29. Group homes are well-funded and OAPP has helped guide us in keeping them a better place for people to live well with AIDS.
30. Improved linkages with case management services (informing the client of services they may access).
31. Good coordination of referrals and services.
32. Task Force meetings improve the delivery of case management services and consumer access to these services.
33. There are effective case management standards of care–on-going client contact and case management services that are client-driven and client-centered.
34. Annual case f that focuses on skills-building for case managers.
35. Case Managers can advocate on behalf of the consumer and remove barriers to care.

*These are based on comments from PLWH/A, providers and Commissioners and are not independently confirmed or verified.

Table 2-2 Weaknesses of the HIV Care System

Program Support / OAPP

1. Lack of effective capacity building to strengthen and empower PLWA.
2. OAPP inability to keep timelines on RFP process and contract functions, forcing contractors to delay service delivery.
3. Difficult client tracking System (IMACS/Casewatch/Toolbox).
4. No system of referral tracking.
5. Insufficient monitoring to avoid duplication of services by providers.

Commission

6. Management of conflict of interest among Commission members.
7. Rushed priority setting process.
8. Relationships between Commission, Board of Supervisors and OAPP.
9. Commission relies too heavily on OAPP for support.
10. Need improved training and support at SPA-level.
11. Utilization of evaluation to improve practices.
12. Under-representation of youth, adolescents, and families on Commission.
13. No regular assessment of policies and practices.
14. Poor response rate from Commissioners asked to participate in the planning process.
15. Identification of community training needs.
16. Lack of centralized comprehensive consumer information.

Service Delivery

17. ASOs do not have sufficient consumer participation.
18. Competition between ASO for consumers.
19. More development of service standards that are flexible and client-centered.
20. Better process of case management transitions needed.
21. Need better case management training.
22. Little system-wide family case management.
23. Coordination with housing programs, especially helping PLWH/A to find long-term housing.
24. Lack of coordination with other planning bodies and organizations, such as STD and substance abuse programs.
25. Inclusion of complementary therapies in continuum of care.
26. Difficulty arranging transportation for PLWH/A.
27. Little activity to help PLWH/A to work or coordinate with vocational programs.

*These are based on comments from PLWH/A, providers and Commissioners and are not independently confirmed or verified.

OBJECTIVES

This section details the EMA's primary objectives for the next three years. They are based on workshops conducted with the P&P Committee, feedback from Commissioners, consumers, providers and community members, strategic planning objectives, the implementation plan presented in the FY 2002 Ryan White CARE Act Title I application, and other proposed and developing initiatives and projects.

The first objectives delineate service goals. The second set of objectives facilitate program support, and the final set outline Commission goals and activities. The objectives are designed to meet the needs of eligible PLWH/A throughout the county, resolve unmet needs and service gaps, and overcome barriers and disparities noted earlier in this Plan.

Service Goals and Objectives: System-Wide

Goal

1. **Implementing the Continuum of Care** will be a pivotal effort over the next three years as Los Angeles County's HIV/AIDS service delivery system is brought into conformity with health management practices dictated by a primary health care core to which every client must have access.

Objectives

1. In partnership, the Commission and OAPP will provide community education on the new continuum throughout Los Angeles County eliciting comment, feedback and input from consumers, providers and members of the public.
2. The Commission and OAPP will redefine service categories and delivery in accordance with the new continuum of care.
    2.1. Special emphasis will be placed on partnerships and linkages necessary to ensure all clients have access to the primary health care core of services.
3. RFPs for selected service categories developed and released; procurement of services begins.
    3.1. Extensive provider education offered to help ASOs familiarize themselves with a redefined and modified service system.
4. Service definitions, units of service, outcome measures, indicators and standards of care corresponding to the new continuum are incorporated into new contract language.
5. Technical assistance made available to providers as they begin offering services in accordance with the new continuum of care.

Goal

2. Coordinated Care will reduce the proportion of Los Angeles County residents (1) who test HIV+, but do not return for their results, (2) mitigate the delays between testing HIV+ and entering an HIV system of care, and (3) improve local ability to appropriately screen clients for service eligibility, therein maximizing of Federal resources of last resort.

Objectives

1. Implement technology improvements:
   - 1.1. Development of a real-time web-enabled, integrated data and technology system, HIV Information Resources System (HIRS). HIRS will enable OAPP to track client-, provider-, contract- and service-level service delivery, program progress, management information, and fiscal data. It will also improve OAPP's and providers' ability to more effectively and efficiently track and report HIV service delivery, its impact, and its costs.
   - 1.2. A complementary component, HIV/AIDS Interface Technology System (HITS) is a system that will be designed to ensure that the post-test return rate for persons testing HIV+ is maximized, that all persons testing HIV+ are effectively linked into care, and that mandated eligibility screening for people seeking CARE Act-funded services has effected the maximum use of alternate payer sources (such as MediCal, Medicare, private insurance and VA benefits). HITS will provide:
     - 1.2.1. Automatic and online referral across multiple sites;
     - 1.2.2. Electronic-mail messaging between HIV/AIDS service delivery staff including certified HIV counselors, case managers, and other prevention, care services and treatment personnel in the network of OAPP-funded providers;
     - 1.2.3. Automatic referral scheduling across service delivery sites;
     - 1.2.4. System-wide access to client records; and
     - 1.2.5. Cross referencing of CARE Act service eligibility status to agency payment and invoicing information.

See Attachment 13 for additional details.

Service Goals and Objectives: Primary Health Care

Primary health care is designed to ensure proper medical attention, treatment and care.

Goal

1. **Creating Access to Early Intervention Services in All Regions of Los Angeles County** will serve as integral component of Los Angeles County's core primary health care services to people with HIV/AIDS by ensuring that eligible clients are transitioned into the EMA's care and treatment services system according to accepted standards.

   Objectives

   As part of an overall plan to deliver SPA-based services, partnering with Early Intervention Services (EIS) and other providers outside the CARE Act-funded system in all eight SPAs will link clients with medical care, promote cross-service referral, identification of and collaboration with points of entry into the CARE system, reduce barriers that might impede access to the care system. SPAs will be provided profiles of the vulnerable populations to assist them in locating and targeting effective prevention and care messages to encourage testing and participation in early treatment services. Particular focus will be on EIS for populations highly vulnerable to HIV infections, including gay and bisexual youth Anglo and youth of color; African Americans, and drug users. Linking EIS with medical care will facilitate access to early treatment, along with patient education and nutritional counseling.

   Providers will be trained in culturally and linguistically appropriate service delivery in order to increase the satisfaction of PLWH/A.

Goal

2. **Ambulatory/Outpatient Medical Services (Medical)** will serve as the core component of Los Angeles County's core primary health care services to people with HIV/AIDS through the management of the client's HIV disease, prevention and treatment of opportunistic infections, promotion of optimal health, and provision of the tools to model and guide successful behavior change consistent with PHS standards.

   Objectives

   1. Provide standard intake to all persons entering outpatient primary care including eligibility screening and acuity scaling for clients.
   2. Provide professional diagnostic, therapeutic, and educational medical services at community-based and County clinics in each of the eight Los Angeles County (Los Angeles County) service provider networks (SPAs). This will include
      - 2.1.1. Viral resistance testing (genotypic and phenotypic) for patients during their acute phase of infection or as a measurement for pharmaceutical maintenance, syphilis serology screening upon intake and entry into care.
      - 2.1.2. Counseling on the promotion of well-being, healthful living and treatment care goals for each patient at each medical visit through culturally and linguistically appropriate communications.

2.1.3. Counsel and refer sexual partners and social network affiliates for appropriate screening and medical services.

2.1.4. Health education/risk reduction counseling will be an integral component of every medical appointment by providing client-centered counseling and risk reduction education on at least a quarterly basis.

3. Highly vulnerable populations such as African Americans and young gay men will be targeted for intensive primary medical care and adherence services.
4. Eligibility and acuity rating updates will be performed with clients on annual basis.

Goal

3. Ambulatory/Outpatient Medical Services (Specialty) will serve as a core component of Los Angeles County's core primary health care services to people with HIV/AIDS by managing the client's HIV disease through referral and treatment of specific types of medical conditions requiring specialist attention consistent with PHS standards.

Objectives

1. Monitor and provide specialty services to women living with HIV/AIDS. It is expected that demand will grow as the number of women in the care system increases. Notably, OB/GYN is funded under both regular outpatient care and specialty care.
2. Continue to make ophthalmologic services available to PLWH/A in the care system.
3. Monitor and make specialty services available to respond to specific needs of under-served populations entering the epidemic, and on long-term survivors.

   3.1.1. As persons live longer with HIV and AIDS there will be an increased incidence of cancers, gastrointestinal, gastrointestinal, ENT, dermatological and neurological diagnoses requiring specialty care.

   3.1.2. Among long-term survivors, cancers appear to increasing. As the new client tracking system is employed, the EMA will begin estimating specialty service need based on history. Add to this the general aging of the PLWH/A and related medical problems exacerbated by HIV and it is expected that need for specialty services will increase.
4. As county clinics are closed due to the Los Angeles County health services fiscal crisis, there will be a shift in the HIV/AIDS funding of specialty services to CARE Act-funded providers.

Goal

4. Mental Health Services (Psychiatric) will serve as a core component of Los Angeles County's core primary health care services to people with HIV/AIDS through the provision of accessible and effective psychiatric medication management to ameliorate mental disorders consistent with PHS standards.

Objectives

1. Provide psychiatric diagnostic services, medication evaluations and psychotropic medications for medically indigent persons with HIV evidencing serious mental disorders.
2. Provide medication monitoring services to evaluate clinical responses, alter medication plan as needed, and improve patient's functioning in order to better adhere to medical treatment.
3. Develop specialized mental health services for transgender, monolingual Latinos, and clients with significant co-morbidities (e.g., mental illness, substance abuse, homelessness, etc.).

Goal

5. **Mental Health Services (Psychosocial)** will serve as an integral component of Los Angeles County's core primary health care services to people with HIV/AIDS through the provision of treatment for mental health issues consistent with PHS standards.

Objectives

Severe and chronic mental illness has a high rate of co-morbidity with HIV and substance use. The overall objectives of counseling are to:

1. Provide individual mental health therapy to help stabilize clients in care and facilitate clients into primary health care.
2. Involve clients in group therapy as a means of exposure to an environment which helps them improve their social interaction/interpersonal skills and learn mental health problem-solving skills.
3. Offer family/conjoint therapy counseling to enhance the quality of emotional/mental health of the partners/family and other significant relationships, and enable those affected to support family members' adherence to drug regimens and compliance with HIV treatment.
4. Require the availability of bereavement and grief counseling in the context of all mental health services.

Goal

6. **Oral Health** will serve as an integral component of Los Angeles County's core primary health care services to people with HIV/AIDS through the provision of specialized dental services throughout the County consistent with dental care standards and regulations**.**

Objectives

Both unmet need and unmet demand for dental care is high, and unlikely to be met solely by CARE Act-funded services. Given the high demand, the objectives are to:

1. Make sure the service is available to PLWH/A equally by arranging for oral health providers in all SPAs through direct or referral care.
2. Ensure that CARE Act-funded dental care is provided to persons without other means to pay for it, particularly among PLWH/A of color who lack access to care.

3. Dedicate capacity building funds to the development of increased dental services fairly distributed throughout the EMA in order to identify traditional (e.g., Part F) and non-traditional (e.g., private) funding sources for the development of dental services.

Goal

7. **Nutritional Counseling** will serve as an integral component of Los Angeles County's core primary health care services to people with HIV/AIDS by helping them improve their nutritional choices and educating them on the nutritional ramifications of HIV through assessments and ongoing sessions with registered dieticians consistent with nutritional counseling standards and regulations.

Objectives

Food services are in great demand, while funds set aside for food services have been underspent in the past years. Nutritional counseling will help clients maximize the efficacy of food services. To better meet the expressed demand of PLWH/A, this objective includes:

1. Facilitating improvement in overall nutritional health and knowledge through assessments and on-going counseling at agencies providing other food and nutritional services.
2. Improve overall nutritional health and knowledge through assessments and on-going counseling at medical outpatient providers.
3. Linking PLWH/A to non-CARE Act-funded food services.

Goal

8. **Treatment Adherence** will serve as an integral component of Los Angeles County's core primary health care services to people with HIV/AIDS by helping clients ensure readiness for and adherence to complex HIV/AIDS and co-morbid treatments consistent with treatment adherence standards and regulations**.**

Objectives

With adherence being relatively low among PLWH/A, particularly among Latinos, the objectives for the next few years is to ensure compliance with complex HIV/AIDS medical treatments by:

1. Adopting "best practice" models and alternative service delivery strategies for treatment adherence services.
2. Creating individualized treatment adherence plans including personalized intervention, and emotional support to address treatment compliance/adherence, alternative medicines, and to teach communications skills with medical professionals.
3. Helping clients learn the implications of partial and/or non-adherence to multi-drug regimens.
4. Publishing newsletters and releasing research including HIV/AIDS medical updates, and hosting group presentations/public forums on clinical trials and alternative therapies.
5. Providing emotional and educational support in English and Spanish for clients experiencing treatment adherence problems.

6. Providing specialized TB treatment adherence services to HIV/TB co-morbidly affected clients.

Goal

9. **Substance Abuse Services** will serve as an integral component of Los Angeles County's core primary health care services to people with HIV/AIDS by augmenting and supplementing Los Angeles County's existing services for HIV positive substance using clients according to both harm reduction, maintenance and abstinence models consistent with substance abuse standards and regulations.

Objectives

The overall objective is to provide treatment to persons with co-morbidity of injection and non-injection drug use in order to stabilize their living situations and improve their ability to access and benefit from medical care including adherence to medical appointments and medication regimens. This can be done by:

1. Providing methadone maintenance drug treatment for individuals with narcotic addictions.
2. Providing inpatient medical detoxification services for addicted substance users.
3. Providing inpatient rehabilitation services for addicted substance users.
4. Providing outpatient substance abuse counseling services in structured day treatment settings.
5. Securing space in sober living transitional housing environments, which include substance abuse counseling services for clients who have just completed residential substance abuse treatment services.
6. Providing emergency substance abuse counseling to HIV+ clients in County-funded residential facilities in order to preserve housing stability.
7. Providing short-term substance abuse counseling to HIV+ clients in County-funded residential facilities in order to prevent significant interruptions in HIV care.

Goal

10. **Hospice Services** will serve as an integral component of Los Angeles County's core primary health care services to people with HIV/AIDS by providing full-time medical shelter and attention to clients with prognoses of imminent death consistent with hospice care standards and regulations.

Objective

With decreasing number of person dying of AIDS, there is limited demand for hospice services. Still, the objective of these services is to provide quality end-of-life care in licensed residential hospice settings for clients in severe medical need.

Goal

11. **Home Health Care** fills a gap in services and reduces the need for costly inpatient care. It includes the provision of services by homemakers, home health aides, personal caretakers and/or attendant caretakers. This definition also includes non-medical, non-

nursing assistance with cooking and cleaning activities to help disabled clients remain in their homes and which are consistent with home health care standards and regulations.

Objective

Although not funded by CARE Act Title I or II funds in Los Angeles County, home health care is provided to persons who need professional and paraprofessional care to treat their HIV infection. The objective is to assure that any CARE Act-funded home health care services is limited to high acuity clients (e.g., those at end stages of the disease).

Service Goals and Objectives: Removal of Barriers

Removal of barriers is meant to facilitate the optimal "critical paths" through the continuum of care.

Goal

1. **Food Bank/Home Delivered Meals/Nutritional Supplements** will facilitate and support clients' access to, maintenance of, and adherence to primary medical and health care services by providing culturally appropriate and balanced food products, meals and dietary supplements to meet the nutritional needs of PLWH/A consistent with nutritional and dietary standards and regulations.

Objectives

The unmet demand for food services, particularly vouchers, is high. Poverty is strongly associated with food needs. As PLWH become more mobile, food vouchers are in greater demand. The challenge is how to equitably distribute food services in the different SPAs and to assure that they are provided with appropriate links to care. The specific objectives are to:

1. Deliver professionally prepared meals to clients in each of the eight SPAs.
2. Implement food bank services providing culturally and nutritionally appropriate food products and supplements from at least one site in each of the eight SPAs.
3. Distribute grocery vouchers to clients in settings where they receive medial or wrap-around services, focusing on those special populations where food pantry/food bank services might not be as effective (e.g., homeless, IDU/NIDU, transportation-challenged, etc.)

Goal

2. **Housing Assistance** will facilitate and support clients' access to, maintenance of, and adherence to primary medical and health care services through the provision of short-term housing to people who require shelter due to crisis, emergency, or certified necessity, in order to strengthen their ability to access or maintain primary medical care. Housing assistance will be provided according to established housing standards and regulations.

Objectives

Housing, like food, is an unmet need of many PLWH/A who live below poverty. In Los Angeles County utilization of non-CARE Act-housing funds, including HOPWA, are poorly coordinated to meet the needs of PLWH/A. The situation is further exacerbated by a chronic housing shortage.

1. One of the Commission's primary objective is to coordinate service delivery with HOPWA [and its governing body, Los Angeles Countywide HOPWA Advisory Council (Los Angeles CountyHAC)], recognizing that CARE Act funds are restricted to specialized housing assistance.
   1.1. Creation of an advisory board comprising to Commission, OAPP, HOPWA and Los Angeles CountyHAC members to better enhance coordination of housing services to people with HIV/AIDS.

2. In addition, the CARE Act-funded housing services will include:
   2.1. Short-term temporary housing designed to support medical and related psychosocial services;
   2.2. Transitional housing designed to support medical and related psychosocial services;
   2.3. On-site case management services and/or referrals to off-site case management services;
   2.4. On-site substance services and/or referrals to off-site substance abuse services;
   2.5. On-site mental health services and/or referrals to off-site mental health services.

Goal

3. Transportation will facilitate and support clients' access to, maintenance of, and adherence to primary medical and health care services by providing indigent clients with private and public transportation to and from treatment and other necessary services within the limits of established standards and regulations.

Objectives

With a relatively high unmet need among women, African Americans, Latinos, and the recently incarcerated, the objectives are to:

1. Help clients recently released from correctional facilities access the care system by providing them with transportation linking them directly into services;
2. Develop a better tracking system, eligibility requirements, and standards for transportation services in order to improve/maximize cost efficiency and reduce waste of services;
3. Provide transportation to clients to help them access services, with priority given to medical, mental health appointments, substance abuse programs, and public benefit appointments; and
4. Move newly affected clients from counseling and testing sites directly into care system by transporting them to primary medical providers and/or social service providers.

Goal

4. Childcare will facilitate and support clients' access to, maintenance of, and adherence to primary medical and health care services by providing State Title XXII-regulated childcare services to parents/guardians while they go to medical and support service appointments.

Objective

Childcare is not in great demand by a majority of clients, but given the increasing number of families with children where a parent is infected, it can be a significant barrier to some families' access to services. Funds should permit childcare when it will facilitate access to regular medical appointments and support services for parents/guardians. Childcare should be made available in all SPAs.

Goal

5. **Client Advocacy** In Los Angeles County, client advocacy will be directed toward enhanced counseling focusing on benefits and eligibility for non-CARE Act-funded services.

Objective

Client advocacy has not been directly funded in the recent past. The needs assessment suggests, however, that PLWH/A and their providers are not accessing all non-CARE Act-funded services possible. The objective for this service is to help clients and providers access non-CARE Act funds and other forms of reimbursement for services.

Service Goals and Objectives: Patient Care Coordination

Patient care coordination is aimed at enhancing patient's ability to access the care services system and to stay in care.

Goal

1. **Case Management (Psychosocial)** will facilitate and support individual and family clients' access to, maintenance of, and adherence to primary medical and health care services through assessment, monitoring and linking to federally- and non-federally-funded financial, benefits and other support services within the confines of existing standards and regulations.

Objectives

The care system has considerable capacity for psychosocial case management. The objectives over the next few years are to provide more standardized service, based on acuity and corresponding to individual and family service plan. Specially the objectives are to:

1. Conduct intakes and comprehensive review and assessment of individual and family clients' psychosocial needs and acuity levels (family services will focus on promoting support of HIV+ members by other family members, including significant others and partners).
2. Stratify case management services based on level of acuity, and ensure access to case management services for all high-acuity clients.
3. Develop and implement Individual Service Plans (ISPs) for individuals and Family Service Plans (FSPs) in order to identify goals and steps of case management service provision
4. Implement, monitor and follow-up with I/FSPs by connecting individual and family clients to other health care and support resources.
5. Provide intensive case management and treatment adherence services to clients of color who may be disenfranchised from and unable to access the care system due to additional race- and economically-related factors.

Goal

2. **Case Management (Medical)** will facilitate client access, utilization, retention and adherence of primary health care core services through ongoing assessments, monitoring by coordinating clients' medical, physical, psychosocial, and support needs according to case management standards and regulations.

Objectives

In the past, medical (or inpatient) case management has not been the focus of care coordination activities. However, with the heightened emphasis on ensuring access to medical care, the objectives for the next few years include:

1. Begin integrating medical case management into all psychosocial case management services. Differentiate between medical and psychosocial case management in case management standards, and incorporate distinctions into contracts.
2. Maintain or upgrade client health through regular assessments, on-going monitoring sessions, coordination with psychosocial case management and other support services, and appropriate follow-up.

3. Provide intensive medical case management and treatment adherence services to clients affected by both HIV and TB/STDs at outpatient medical sites.
4. Enhance case manager professionalism and expertise through certification, ongoing training and stricter adherence to case management and medical outpatient standards (based on consumer forum feedback).

Goal

3. Referral will facilitate and support clients' access to, maintenance of and adherence to primary medical and health care services by bringing recently tested HIV+ individuals into the primary medical and support service network.

Objectives

Referrals for the newly infected will be facilitated by the HITS system and will be contingent on having a client tracking system that is linked to counseling and testing. At the same time, making services more known to all providers will assist in making appropriate referrals. The objectives of referral services are to:

1. Integrate referral from HIV Counseling and Testing sites into the case management network by linking clients who test positive into primary health care and patient care coordination.
2. Increase coordination of referrals to non-CARE Act-funded services, based on eligibility and access.
3. Distribute and track usage of the newly developed English and Spanish paper and web-enabled resource directories.

Goal

4. Translation/Interpretation Services will facilitate client access, utilization, retention and adherence of primary health care core services by providing interpretive services to non- or limited-English speakers and/or the deaf/hearing impaired in accordance with established standards and regulations.

Objectives

With the large populations of Latino and API monolingual PLWH/A, there is an increased need for non-English speaking services. In the 2002 Needs Assessment, one oft-cited reason for clients not seeking services was lack of comfort with the providers who did not speak their language or know their customs.

The objectives are to:

1. Adopt "best practice" models and alternative forms of service delivery for translation/interpretation services;
2. Strengthen translation/interpretation standards, guidance, training and promotion;
3. Provide interpretive and direct translation services to monolingual Latino, Asian/Pacific Islander clients and their immediate family members at, most importantly, medical service settings.
4. Provide ASL translation services to deaf and hearing-impaired clients and their immediate family members at, most importantly, medical service settings.

Service Goals and Objectives: Economic Well-Being

Economic well-being is aimed at ameliorating the conditions of poverty, mitigating economic barriers to access, and enhancing workforce re-entry.

Goal

1. **Legal Services** will mitigate the impact and ramifications of debilitating economic conditions by providing relevant legal advice, support, and intervention necessitated by legal challenges due to an individual's HIV/AIDS status. Legal services will be provided within established standards and regulations.

Objectives

1. Secure public benefits for HIV+ clients through legal representation, services and education.
2. Reduce the effects of HIV/AIDS discrimination in home, work and other environments through the provision of legal representation and services.
3. Help recent immigrants who are HIV+ access and maintain medical care and other support services by providing them with legal representation, assistance and education.
4. Provide Durable Power of Attorney (DPOA), Do Not-Resuscitate Orders (DNR) and other end-of-the-life testamentary documentation.
5. Improve client access and linkages to other forms of legal service not currently available in the system of care (e.g., criminal, personal injury).

Goal

2. **Permanency Planning** will mitigate the impact and ramifications of debilitating economic conditions by stabilizing the individual's and the family's end-of-the-life planning needs.

Objective

Permanency planning provides for the preparation of custody options for legal dependents including standby guardianship, joint custody and/or adoption.

Service Goals and Objectives: Enhancement Services

Enhancement Services will improve the quality of life of PLWH/A and their families to ensure that their primary medical care and support services can be effectively administered.

Goal

1. **Psychosocial Support Service (Peer Support)** will facilitate the client's ability to address HIV-related issues by interacting in a non-professional counseling environment of others experiencing the same situations, ultimately resulting in a greater sense of empowerment, self-advocacy and self-management which enhances the overall health status of the client. These services will be provided within the standards and regulations established by the Commission.

Objectives

Peer and buddy support has not received significant support by CARE Act funds as the care services model transitions to a more medically-oriented format. However, based on the needs assessment and demand for peer support by women and communities of color, funds have been allocated with the objectives to:

1. Provide one-to-one peer and paraprofessional support to clients at various sites, including medical, social service and residential venues in all eight SPAs.
2. Provide education/support groups facilitated by trained peers facilitators in all SPAs.
3. Collaborate with faith-based-funded organizations in the community to develop standards and training for churches, synagogues, mosques and other religious institutions to provide supportive pastoral/spiritual care to clients.
4. Provide training and certification for peer counselors, emphasizing the scope and limitations of peer support services.

Program Support Goals and Objectives

Program support goals and objectives enhance overall quality of care in the EMA by building, supporting and improving organizational capacity, and provider and system capabilities.

Goal

1. **Service Coordination** will enhance the cross-service efficiency, increase the participation of local entities in community health planning, and provide a platform to identify unique demographic, service, geographic and other needs in each SPA.

Objectives

1. To better coordinate providers on a geographic basis, OAPP has begun establishing Service Provider Networks (SPNs) in all eight SPAs. These networks coordinate and integrate local HIV/AIDS health management systems and the prevention Coordinated Prevention Networks (CPNs) initiative (See Attachment 14 for the SPN plan).
2. In order to better facilitate client-level service delivered between providers, the EMA will develop a real-time web-enabled client-level data reporting, tracking and collection system for system-wide use by 2005.
3. Common intake forms will be designed and integrated into the new data management system in order to develop acuity scales, ascertain eligibility for CARE Act-funded and other services, and to track progression and stages of the disease in individual clients.
4. Information on non-CARE Act-funded providers and services will be disseminated to providers in order to ensure CARE Act services are used as a last resort.

Goal

2. **Capacity Building** will protect the CARE Act investment made in local community health care provision by sustaining community providers with skills-building, infrastructure, development, technical expertise and support services to ensure continued ability to efficiently and cost-effectively serve PLWH/A.

Objectives

1. Continue to support ongoing technical support and infrastructure development and strengthening for local agencies needing continued guidance and expertise on issues of agency maintenance and growth.
2. Implement new capacity building projects for ASOs needing guidance and expertise on issues of agency maintenance and growth, particularly among providers serving communities and populations disproportionately impacted by HIV/AIDS, such as African Americans and young gay/bisexual men.
3. Provide technical assistance to develop provider ability to access and bill MediCal and Medicare for eligible clients.
4. Establish a Technical Assistance Clearinghouse Database to help ASOs access information and technical expertise in specific capacity development areas.

5. Evaluate capacity building projects.

Goal

3. Service Enhancement will elevate service provision efficiency and responsiveness by refining quality of care, decision-making and implementation processes.

Objectives

1. Create an in-house service bureau of experts who provide technical support that can be accessed by providers. Experts will include:
   - 1.1.1. Pharmacist (especially focusing on linkages to ADAP and clinical trials),
   - 1.1.2. Nutritionist/Dietician,
   - 1.1.3. Substance Abuse specialist,
   - 1.1.4. Benefits counselor (especially emphasizing client access to alternative funding sources/services),
   - 1.1.5. Psychiatrist,
   - 1.1.6. Adherence specialist, and
   - 1.1.7. Dentist.
2. Develop real-time client tracking system that integrates service descriptions, definitions, units of care and costs into service system data collection and tracking mechanisms.
3. Develop uniform protocol to estimate PLWH/A acuity and disease progression, and update at least annually.

Goal

4. Evaluation will give the Commission, OAPP and providers information important to the process of assessing program relevancy, use and effectiveness in a constantly changing health care service arena.

Objectives

1. Priority service categories to be evaluated include:
   - 1.1.1. Substance Abuse,
   - 1.1.2. Residential (including hospice),
   - 1.1.3. Mental health,
   - 1.1.4. Transportation,
   - 1.1.5. Food,
   - 1.1.6. Medical case management,
   - 1.1.7. Referrals,
   - 1.1.8. Oral health, and
   - 1.1.9. Treatment Adherence.
2. Assess access and quality of services provided including cultural and linguistic appropriateness.

3. Assess compliance with eligibility criteria.

Goal

5. Training and Education will upgrade the talents, skills and expectations of professional, care and support staff at various providers in an effort to ensure the best services, data collection and standards of care are available to all clients throughout the County.

Objectives

1. Phase in uniform usage of the Casewatch data collection system prior to the development of the real-time web-enabled client tracking and reporting system, and provide continual on-going data management training to providers.
2. Train nurses and physicians on Health Education/Risk Reduction, patient education and its mandatory inclusion in all patient visits, per standards of care.
3. Train substance abuse counselors throughout the County on all areas and issues surrounding HIV/AIDS and injection and non-injection substance abuse co-morbidity.
4. Develop training module on individual and family service plans that is compatible with acuity scale measurement.
5. Provide training to case managers/benefit counselors on ways in which clients can work while preserving their benefits for case managers and development of materials for PLWH/A.

Goal

6. Rate and Fee Review: will provide the EMA with the best data, research and knowledge regarding fee-for-service rate and reimbursement plans, their methodologies and ways in which they can be successfully implemented for clients, providers and the administrative agency.

Objectives

1. Establish fee-for-service reimbursement plans for outpatient medical services, patient care coordination, substance abuse services, and residential services (including hospice).

Goal

7. Program Development will incubate and develop programs to test their efficacy in the local environment, quality of service delivery and to identify challenges in their implementation.

Objectives

Based on best practices research and needs assessment findings, the Commission and OAPP will enhance or develop:

1. Programs designed to assist multi-diagnosed clients who have difficulty accessing appropriate care, focusing their services on treatment retention, disease management and mental health stability;
2. Translation/interpretations services at outpatient medical care facilities;

3. Buddy/companion, paraprofessional and peer-to-peer support programs to improve adherence and emotional support for PLWH/A; and
4. Transportation services linking HIV+ clients newly-identified at counseling and testing sites and newly released from incarceration facilities directly into care services.

Commission Support Goals and Objectives

Commission Support Goals and Objectives ensure that the Commission fulfills its legislative mandates, including, but not limited to, incorporating consumer/community participation in planning and delivery of HIV Health services throughout Los Angeles County.

Goal

1. **Implementation of a Separate Staffing Pattern for the Commission** will reduce the potential of conflicting priorities and agendas between the administrative agency and the local planning council, and ensure that each body is able to effectively implement its legislatively mandated responsibilities.

Objective: Transition from an OAPP-supported Commission to a planning council with its own staff and direction. This objective has been one of the major recommendations of the Strategic Planning effort, submitted by the Core Planning Partners (Commission, PPC and OAPP). It is expected to be approved by the end of 2002, and implemented in 2003. There are three recommendations:

1. The Commission be staffed by a professional managerial team consisting of a Commission Director, and four managers for Planning, Evaluation, Operations and Membership. The full model and staffing plan can be seen in "A Staffing Model of The Los Angeles County Commission on HIV/AIDS Health Services", February 14, 2002.
    - 1.1.1. The positions in the managerial team relate directly and specifically to the Ryan White CARE Act legislated roles and responsibilities for the Commission
    - 1.1.2. The managerial team will improve the quality and the sophistication of the Commission's work products, deliberations and decision-making as a means of improving planning outcomes.
    - 1.1.3. The Commission managerial team must compare in stature and level of responsibility with the OAPP managerial team.
    - 1.1.4. A Commission with its own managerial team will establish itself as a full planning partner along side of the OAPP and Board of Supervisors.
2. An Office of HIV/AIDS Commission Affairs will be established within the Offices of the Chief Elected Official, the Los Angeles County Board of Supervisors, where the staff will be employed and all Commission management functions will be housed.
    - 2.1.1. This will strengthen the partnership between OAPP, the Commission and the CEO.
    - 2.1.2. These arrangements will provide sufficient separation in the duties of OAPP, Commission and CEO.
    - 2.1.3. The Commission will benefit from the expedited contracting and personnel approval process enjoyed by the Los Angeles County Board of Supervisor Offices.
3. The Commission committee structure will be revised to specifically address the Ryan White CARE Act program requirements.

3.1.1. Because of the new HRSA:HAB principles and related principles and program expectations, evaluation must now assume an equally attended place with planning and related program expectations.

4. The Core Planning Partners will solicit an implementation consultant or CEO-designated staff to directly assist the Commission, OAPP, and the CEO in following through with these recommendations.

Goal

2. Consumer Involvement Efforts will be implemented to ensure greater and more expansive participation by consumers in the EMA's planning and decision-making activities (see Attachment 17 for details).

Objectives

1. Institutionalize consumer involvement at the SPA level by requiring the eight Service Provider Networks (SPNs) to each create a Consumer Advisory Board (CAB) for their respective SPAs by 2003.

   1.1.1. SPNs will be expected to recruit CAB members from the existing provider CABs, local SPA consortiums and other consumer councils—as well as consumers not currently affiliated with any of those bodies—and coordinating planning and other activities among those groups.

2. By 2004, the Commission will create a county-wide "Consumer Council" to advise and inform the Commission on matters related to consumer need and perspective.

   2.1.1. The SPNs' CABs will refer and recommend members of their respective CABs onto the Consumer Council.

   2.1.2. In 2003, the Commission's P&P and RD&B Committees will develop the structure of the Consumer Council, including membership, relationships with CABs, roles and responsibilities.

   2.1.3. The Commission will invest the Consumer Council with some "real authority" to inform different aspects of the Commission planning processes.

3. The Commission will recruit consumer planning council members from the Consumer Council and SPNs CABs.

Goal

4. **Planning, Priority- and Allocation-Setting Activities** will be conducted throughout the year to ensure proper allocation of resources and funds to meet the community's and clients' HIV/AIDS related care and treatment needs.

Objectives

1. Modify the priorities and allocations process schedule to *(*for detail see Attachment 15*)*:

   1.1. Advance Year 14 priority- and allocation-setting from June/July 2003 to February/March 2003. As a result, the Commission will not be able to conduct a full, completely new needs assessment for the Year 14 priority- and allocation-setting process.

1.2. Once the Year 14 priority and allocation-setting process is concluded in March 2003, the P&P Committee will immediately initiate the solicitation/selection of the Year 15 needs assessment consultants. This will give the Commission enough time to conduct a full needs assessment for the following year.

1.2.2. This will be the needs assessment cycle for subsequent years. The Commission will be able to solicit for "second generation" needs assessments per strategic planning recommendations.

1.3. Rather than conducting a new needs assessment for Year 14 priority- and allocation-setting, the Commission will update and refine its Year 13 priorities and allocations. The P&P Committee will update Year 13 priorities and allocations for Year 14 with information generated by the financial needs assessment. The P&P Committee will refine Year 13 priorities and allocations for Year 14 with SPA-based and subpopulation-based data/information.

1.4. With less time devoted to priority- and allocation-setting at the onset of Year 13, the P&P Committee will devote its attention to other important activities:Completing the revisions of the Comprehensive Care Plan and developing strategies to educate the community about it.

1.4.2. Working with the administrative agency to implement the new continuum of care.

1.5. The P&P Committee will conduct a consumer expressed need data-gathering from December 2002 – January 2003.

2. Begin on-going, continuous data collection and analysis, rather than a one-time a year effort. Continuous data collection is a primary needs assessment recommendation from the LA County HIV/AIDS Strategic Planning Process. This will allow for the periodic updates of the needs assessment as data becomes available including:

   2.1. Establish a continuous data collection protocol for collecting needs assessment data;

   2.2. Review and recommend maximum levels of available services in each service category (based on unit costs) after the completion of the financial needs assessment;

   2.3. Assess alternative sources of funding based on findings from the financial needs assessment; and

   2.4. Report causal factors of cognitive and structural barriers to care (due to stigma, disparities, denial, etc.) and make recommendations for service system delivery modifications to address those needs.

3. Emphasize continued community and consumer participation through community/consumer forums, needs assessment surveys, key informant interviews and secondary analysis.

4. Develop mechanisms to enhance active Commission participation in the needs assessment process.

Goal

4. **Evaluation Activities** will help the Commission ensure that it is overseeing the effective delivery of services, proper disbursement of funds and that the services are meeting the needs of the EMA's clients.

Objectives

1. Assure that the grantee's administrative mechanisms are functioning properly.
2. Review and implement recommendations for improvement of the administrative mechanism to allocate and disburse funds; and increase services.
3. Assess the efficiency and efficacy of services, and measure unmet need and service gaps.
4. Define outcomes and adopt quantitative and qualitative methods to measure outcomes.
5. Improve and enhance grievance procedures, and incorporate as a continuous quality improvement (CQI) measures.
6. Design new evaluation methodologies and outcomes to assess service effectiveness, efficiency and quality for (as first priority).
    - 6.1. Substance abuse,
    - 6.2. Hospice care,
    - 6.3. Mental health,
    - 6.4. Transportation,
    - 6.5. Food,
    - 6.6. Inpatient (medical) case-management,
    - 6.7. Referrals,
    - 6.8. Oral health, and
    - 6.9. Treatment adherence.

Goal

5. **Community Education and Public Advocacy Efforts** will prompt consumer and policy-maker participation and involvement in decisions regarding HIV/AIDS health service planning, priorities and delivery.

Objectives

1. Ongoing public education about HIV/AIDS prevention and care and the impact of local, State and Federal legislation on the prevention and care of PLWH/A, help keep HIV/AIDS on the public agenda, and remind the public of the continuing spread of HIV and the increasing number of PLWH/A who need care.
    - 1.1. Establish Commission speaker bureau;
    - 1.2. Advocate for back-to-work, HMO, disability and other legislative initiatives that would improve the quality of life of PLWH/A; and

1.3. Conduct ongoing public awareness campaign promoting the availability and accessibility of HIV/AIDS services, especially targeting consumers not in care.

Goal

6. Training Activities will afford the Commission the opportunity to enhance the quality of its membership's contribution to planning, decision-making and action.

Objectives

1. Train Commission members in using data for planning; procedures; on HIV/AIDS topics; and about their roles and responsibilities.
2. Develop and implement a comprehensive training program for Commission, Consumer Advisory Board and consumer council members.

Goal

7. Best Practices will entail the study and exploration of various models of care and services across the nation and locally in order to provide Los Angeles County with conceptual frameworks for new and innovative service delivery.

Objectives

1. Research best practices methods for:
   1.1. Peer support and self-help programs,
   1.2. Appropriate provision of language services in medical outpatient settings,
   1.3. Treatment adherence models and protocols,
   1.4. Vocational assistance and workforce training,
   1.5. Medical case management care coordination, and
   1.6. Fee-for-service reimbursement programs.
2. Revise, develop and/or implement standards of care for every Los Angeles County CARE Act-funded service category by 2005.
3. Collaborate with OAPP to develop reliable outcome measures and quality care indicators in every Los Angeles County CARE Act-funded every service category by 2005.

3. HOW WILL WE MONITOR OUR PROGRESS AND RESULTS

The various objectives and tasks can be monitored using a variety of methods. For contracted work, existence of RFPs, disbursement of funds in timely manner, and product (reports, systems, guides) and events (trainings, meetings, seminars, etc) can be tracked. For services, numbers of clients can be tracked as well as outcomes, satisfaction, need and unmet need. Examples are provided below for several of the objectives in the previous section.

Commission Support

Commission Support Goals and Objectives ensures that the Commission fulfills its legislative mandates, including incorporating community participation effective planning and delivery of HIV Health services throughout Los Angeles County.

Goal

1. Implementation of a Separate Staffing Pattern for the Commission will reduce the potential of conflicting priorities and agendas between the administrative agency and the local planning council, and ensure that each body is able to effectively implement its legislatively mandated responsibilities.

Objective: Transition from an OAPP supported Commission to a planning council with its own staff and direction. This objective has been one of the major recommendations of the Strategic Planning effort, submitted by the Core Planning Partners (Commission, PPC and OAPP). It is expected to be approved by the end of 2002, and implemented in 2003.

There are three recommendations:

Objective/Tasks	Monitoring Indicators
1. The Commission be staffed by a professional managerial team consisting of a Director, and four managers for Planning, Evaluation, Operations and Membership. The full model and staffing plan can be seen in "A Staffing Model of The Los Angeles County Commission on HIV/AIDS Health Services", February 14, 2002.	Job descriptions Approved plan Position announcements Interviews Hiring
2. An Office of HIV/AIDS Commission Affairs will be established within the Offices of the Chief Elected Official, the Los Angeles County Board of Supervisors, where the staff will be employed and all Commission management functions will be housed.	Establishment of Office
3. The Commission committee structure will be revised so as to specifically address the CARE Act program requirements.	Review of committee structure and CARE Act program requirements Incorporation into Commission bylaws

2. Planning and Priority Setting Activities will be conduced throughout the year to ensure proper allocation of resources and funds to meet the community's and clients' HIV/AIDS related care and treatment needs.

Objective/Tasks	**Monitoring Indicators**
1. Modify the priorities and allocations process schedule.	Adoption of new schedule by Commission
2. Begin on-going, continuous data collection and analysis, rather than a one-time a year effort. Continuous data collection is a primary needs assessment recommendation from the LA County HIV/AIDS Strategic Planning Process. This will allow for the periodic updating of the Needs Assessment as data becomes available including:	
2.1. Establish a continuous data collection protocol for collecting needs assessment data	Protocol written and accepted
2.2. Review and recommend maximum levels of available services in each service category (based on unit costs) after the completion of the Financial Needs Assessment;	Utilization and capacity of services calculated
2.3. Assess alternative sources of funding based on findings from the Financial Needs Assessment.	Completion of Financial Needs Assessment with estimates of non-available CARE Act-funding sources category
2.4. Report causal factors of cognitive and structural barriers to care (due to stigma, disparities, denial, etc.) and make recommendations for service system delivery modifications to address those needs.	Completion of primary needs assessment survey, added questions to ongoing surveys, and analysis.
3. Emphasize continued community and consumer participation through community focus forums, needs assessment surveys, key informant interviews, and secondary analysis.	Consumer/Community focus forums scheduled Protocol on recruitment and methods Focus forums held and data collected
4. Develop mechanisms to increase Commission participation in the Needs Assessment Process.	Training Increased participation

3. Evaluation Activities will help the Commission ensure that it is overseeing the effective delivery of services, proper disbursement of funds and that the services are meeting the needs of EMA's clients.

Objective/Tasks	Monitoring Indicators
1. Assure that the administrative mechanisms of the grantee are working effectively;	Assessment of the administrative mechanisms completed Time between RFPs and contracts reduced Expending all allocated funds in a timely fashion
2. Assess the efficiency and efficacy of services and measure unmet need and service gaps.	Formulas for unmet need, efficiency and effectiveness developed and implemented
3. Define outcomes and adopt quantitative and qualitative methods to measure outcomes.	Definition and operationalization of outcomes
4. Improve and enhance the grievance procedures.	Monitoring of grievances and resolutions Promotion of grievance process
5. Design new evaluation methodologies and outcomes to assess service effectiveness, efficiency and quality selected services.	Design and implementation of evaluation of service effectiveness, efficiency and quality.

4. Community Education and Public Advocacy Efforts will prompt consumer and policy makers participation and involvement in decisions regarding HIV and AIDS health service planning, priorities, and delivery.

Objective/Tasks	Monitoring Indicators
1. Ongoing public education about prevention and care of HIV/AIDS and the impact of local State and Federal legislation on the prevention and care of PLWH/A help keep HIV/AIDS on the public agenda and remind the public of the continuing spread of HIV and the increasing number of PLWH/A who need care.	Establishment of Commission speakers bureau Public awareness campaign targeting consumers and potential consumers

5. Training Activities will afford the Commission the opportunity to enhance the quality of its membership's contribution to planning, decision-making and action.

Objective/Tasks	Monitoring Indicators
1. Train Commission members in using data for planning, procedures, and HIV/AIDS topics, and their roles and responsibilities.	Trainings Monitor improved usage of data by Commissioners in decision-making
2. Develop and implement a comprehensive HIV/AIDS training program for Consumer Advocacy Boards and Service Provider Network Councils.	Written curriculum Schedule training process Actual trainings

6. Best Practices for Services will entail the study and exploration of various models of care and services across the nation in order to provide the local EMA with conceptual frameworks for new and innovative service delivery.

Objective/Tasks	Monitoring Indicators
1. Research best practices methods for: • peer support and self-help program models throughout the nation; • appropriate provision of language services in medical outpatient settings • treatment adherence models and protocols; • vocational assistance; • inpatient (medical case management) models. Make recommendations, rate review for services provided on a fee-for-service model.	Established research project implemented

Program Support

Program Support Goals and Objectives enhances overall quality of care in the EMA by building, supporting and improving organizational capacity and provider capabilities.

Goals

1. Service Coordination will enhance the cross-service efficiency, increase the participation of local entities in community health planning, and provide a platform to identify unique demographic, service, geographic and other needs in each SPA.

Objective/Tasks	Monitoring Indicators
1. To better coordinate providers on a geographic basis, OAPP is providing technical assistance to establish Service Provider Networks (SPNs) in all eight SPAs. These networks coordinate and integrate local HIV/AIDS health management systems and the prevention CPN initiative. (Attachment 14 for SPN plan).	Technical Assistance contracts with selected service providers Local SPN meetings and directives
2. In order to coordinate services between providers, a client database will be developed and used. OAPP is developing a web based real time system that will be tested in 2002 and rolled out in 2003 and 2004.	Implementation of HIV data management system
3. In order to develop acuity ratings and check eligibility, a common intake form will be designed and implanted as part of the new data system.	Development, acceptance and use of common intake form Acuity formulations Ability of system to calculate acuity
4. Information on non Ryan-White providers will be disseminated to providers to enhance coordination of services with providers who do not receive Ryan White funds.	Inclusion of non-CARE Act-funded providers in resource guide Verification of guide accuracy. Tracking on-line usage and distribution of guides

2. Capacity Building will protect the RWCA investment made in local community health care provision by sustaining community providers with skills-building, technical expertise, and support services to ensure their continued ability to serve the public.

Objective/Tasks	Monitoring Indicators
1. Continue to support ongoing technical support and infrastructure development to local agencies needing continued guidance and expertise on issues of agency maintenance and growth.	Progress reports from existing projects New or renewed contracts with existing providers based on progress reports
2. Implement new capacity building projects for ASOs needing guidance and expertise on issues of agency maintenance and growth particularly among populations disproportionately affected, such as African Americans.	Selection of projects Contracts Progress reports
3. Provide TA to develop ability access and bill MediCal and Medicare for eligible clients.	Ability of providers to bill for non-CARE Act-reimbursed services Increased number of MediCal and Medicare clients at providers
4. Establish a TA Clearing House Database for ASO that includes access information to technical experts in specific capacity building areas.	Contract Implementation of TA clearinghouse Tracking utilization
5. Evaluate capacity building projects.	Specific accomplishments compared to projects outcomes

3. Service Enhancement will elevate service provision efficiency and responsiveness by refining quality, decision-making and implementation processes.

Objective/Tasks	Monitoring Indicators
1. Create an in-house service-bureau of experts that provide technical support to that can be accessed by ASO including. Experts include pharmacists, nutritionist, substance abuse expert, benefits expert, psychiatrist, and adherence specialist.	Job descriptions Approval of new staff Interviewing Hiring
2. Develop real time client tracking system that integrate service descriptions and definitions into service system data collection and tracking mechanisms	Utilization of Casewatch Beta testing of new system Roll-out of new system Provider utilization
3. Develop uniform protocol to estimate acuity for PLWH/A, and update at least annually	Development of protocol Formula for estimating acuity

4. Evaluation will give OAPP and community providers information important to the process of assessing program relevancy, use and effectiveness in a constantly changing health care service arena.

Objective/Tasks	Monitoring Indicators
1. Evaluate selected services within the primary health care core, removal of barriers, patient care coordination, and economic well-being. Services to be evaluated include substance Abuse, hospice care, mental health, transportation, food services, inpatient (medical case-management), referrals, oral health, and treatment Adherence.	Evaluation design Report
2. Assess access, quality of services provided including cultural and linguistic appropriateness.	Quality assessment protocol Reports
3. Assess compliance with eligibility criteria.	Ongoing program/administration monitoring

5. Training and Education will upgrade the talents, skills and expectations of professional, care and support staff at various providers in an effort to ensure the best services, data collection and standards of care are available to all clients throughout the County.

Objective/Tasks	Monitoring Indicators
1. Provide ongoing training to every case management provider on the Casewatch (Automated Case Management System) and the newly developed web based client tracking and reporting system.	Hire or assigned training staff Curriculums written and approved Scheduled training Attendance Testing of participants Pre- and posy-training evaluation by participants
2. Train nurses and physicians on HE/RR, patient education, and its mandatory inclusion in all patient visits, per standards of care.	
3. Train substance abuse counselors throughout the County on all areas and issues surrounding HIV/AIDS and injection and non-injection substance abuse co-morbidity.	
4. Develop training module on individualize care plans that is compatible with acuity scale measurement.	
5. Provide training to case managers/benefit counselors on ways in which clients can work while preserving their benefits including of back-to-work for case managers and material for PLWH/A.	

6. Rate and Fee Review: will provide the EMA with the best data, research and knowledge regarding fee-for-service rates and reimbursements, their methodologies and ways in which they have been successfully implemented for clients, providers and administrative agencies.

Objective/Tasks	Monitoring Indicators
1. Establish a fee-for-service for services in the primary health care core and patient care coordination services for substance abuse services, outpatient, and hospice care	RFP Report with capitated rates for services and subservices.

7. Program Development will incubate and develop programs to test their efficacy in the local environment, quality of service delivery and to identify challenges in their implementation.

Objective/Tasks	Monitoring Indicators
1. Based on best practices research and findings from the needs assessment, the Commission and OAPP will develop:	
1.1. Programs designed to assist multi-diagnosed clients who have difficulty accessing appropriate care focusing on treatment retention, disease management and mental health stability.	Implementation of additional programs and protocols for PLWH/A with co-morbidities and adherence problems
1.2. Translators at medical care establishments.	Monitoring placement of translators at medical establishments
1.3. Buddy and peer-to-peer support programs to provide adherence and emotional support to clients with needs.	Assessment of current and future buddy and peer-support programs Client survey of programs
1.4. Transportation services linking HIV positive clients newly-identified at counseling and testing sites directly into care services.	Consistent transportation service utilization data

Program Services

Development of systems, new programs, capacity, and utilization can be monitored using a variety of tools.

Systems development, such as for HITS or and HIRS-enable can be monitored by the Commission and, if necessary, consultants, to determine the feasibility and quality of system design and specifications. Beta testing and roll-out have to be closely monitored to assure that systems are user-friendly, well-documented and compatible with existing hardware, software and protocols.

A key element in monitoring system development is the assurance that adequate resources are allocated to training and technical assistance for providers.

Once services are defined and in place, the client tracking system--whether the existing OAPP service utilization data system or HIRS--will be a primary source of information on utilization by different key client composites and profiles that correspond to each objective (e.g. newly infected, African American, women, youth, geographic subpopulations, etc.).

Several indicators are noted in Table 3-1 below:

Table 3-1 Indicators of Service Planning and Delivery

INDICATORS	COMMENT
Utilization data by service and unduplicated client counts.	The use of OAPP service utilization data currently and the use of the new data management system should monitor utilization by different demographic and behavioral risk groups, including special populations. The completion of accurate data will be a major element in the assessment of services until the new system is in place. Agencies will need adequate technical assistance to make sure the data is complete and timely. The new data management system should be easier for data entry and have flexible reporting capacity. The new systems should capture data common intake forms as a way of monitoring those entering the system and tacking service linkages and utilization.
Contact Monitoring	Uniform contract monitoring forms with key financial, utilization, and financial indicators can provide useful monitoring information for the expenditure of funds and service utilization.
Waiting lists	Waiting lists of services can indicate unmet demand or need for additional capacity. It can also indicate higher quality of service at one provider over another.
Secondary data sources	Existing instruments such as the LA Health Survey, MediCal records, SHAS, Young Men's Survey and other ongoing studies can be used to determine demand and need. In some instances principle investigators might add a few additional questions that help tack and estimate services needs.
Standard of care monitoring	As standards of care are set, tools and training have to be in place to ensure services are monitored and action taken when standards are not met.
Ongoing and periodic needs assessment	The needs assessment can be updated annually and, once the continuous data collection plan is adopted, updated by section at periodic and year intervals. Special populations may be surveyed specifically if data is needed and available.
Epidemiological Review and data	Los Angeles County's HIV Epidemiology program is an excellent partner in providing data on the profile of consumers and the HARS, SHAS, and ASD databases can be invaluable

INDICATORS	COMMENT
	in estimating use and service needs. Within two to three years, HIV surveillance data will also be available and useful.
Collaboration and linkage	Collaborations and linkages can be specified as part of the contract procedures and monitored as part of contract review. Providers might do systematic follow-ups to determine the efficacy of the collaborations.
Client satisfaction	Client satisfaction can be captured by a uniform consumer satisfaction survey and also through consumer feedback and other procedures established by the Commission and OAPP. Currently there is no uniform satisfaction survey, but it can be designed and implemented in subsequent years.
Unit cost information, unduplicated client counts, number of services	Once unit costs are determined, they can be monitored for the quantity of units delivered.
Resource directory	The on-line Resource Directory use can be monitored by "hits," and agencies can be surveyed about its use. A key element of the Resource Directory is keeping data current, which is part of the contract specification and monitoring.
Clients' knowledge of service	Knowledge and utilization of service are collected in the need assessment process.
Selected service assessments	They can address quality, satisfaction, estimated need and current capacity.

4. ATTACHMENTS

Attachment 1 2002 Needs Assessment Survey
Attachment 2 Bibliography
Attachment 3 SPA Descriptions
Attachment 4 Formula for Estimating PLWH/A
Attachment 5 Poverty Levels
Attachment 6 2002 Survey - Demographics
Attachment 7 2002 Survey - Services Needed
Attachment 8 2002 Survey - Services Asked
Attachment 9 2002 Survey - Services Received
Attachment 10 2002 Survey - Service Barriers (Mean Rating)
Attachment 11 2002 Survey - Service Barriers (% w/ Problems)
Attachment 12 Special Population Comparative Data Table
Attachment 13 HIV/AIDS Interface Technology System (HITS) Project Description
Attachment 14 Service Provider Network Plan
Attachment 15 Frameworks Priority and Allocation Setting
Attachment 16 HIV Epi Estimates of AIDS Incidence and AIDS and HIV Prevalence
Attachment 17 Community Advisory Boards and Consumer Involvement

Attachment 1 2002 Needs Assessment Survey

CONSENT FORM
2002 LOS ANGELES EMA HIV/AIDS CARE NEEDS ASSESSMENT

The Los Angeles Commission on HIV Health Services, in collaboration with the Los Angeles County Health Department, is conducting a needs assessment of HIV and AIDS services.

You have been invited to participate in filling out this survey and discussing your experiences, knowledge, and opinions about the service needs for people like yourself living with HIV/AIDS in this forum. This process assures that you have a voice in the planning for HIV and AIDS treatment services throughout the Los Angeles EMA. You will receive $20 in food vouchers for completing this survey.

This survey and forum are entirely confidential. This assurance of confidentiality means that no information about your participation can be obtained by anyone outside staff from PCH and the ASPIRE Group -- the groups hired to conduct the needs assessment. While we ask some questions about your background for the purpose of analysis, your name will never be linked to your answers, and nobody working for any provider or from the Commission will be able to link your comments to your name. The results of this needs assessment may be published, but your name will never be used in any report or publication.

Your consent is entirely voluntary and your decision to participate or not will have no effect on the care you are receiving or the relationships you have with providers and caregivers.

By signing below, you consent to complete the survey.

PARTICIPANT'S SIGNATURE: _____

PARTICPANT'S NAME: _____

Address: _____

City _____ CALIFORNIA Zip Code _____

Telephone: __ __ __ - __ __ __ - __ __ __ __ Date: __ __/ __ __/ 2002

If you have any questions, please call Basil Reyes at (800) 411-4399 x 25.

LOS ANGELES EMA NEEDS ASSESSMENT SURVEY OF PEOPLE LIVING WITH HIV AND AIDS

Sponsored by the Los Angeles Commission of HIV Health Services

INTRODUCTION

Thank you for agreeing to participate in this important survey. Completing this survey gives you a voice in the planning of HIV and AIDS treatment services throughout the Los Angeles EMA.

For each question below, circle or write in an answer. There are no right or wrong answers. Please take as much time as you need to answer each question based on your experiences. If you have any questions or need help reading the survey or interpreting the questions, please ask for assistance.

Your responses are completely confidential. Your name will never be linked to your answers.

Thank you in advance for completing this survey. Please go to the next page.

Confidential ID

We will be obtaining responses from many people living with HIV and AIDS over the next few weeks. Please create a confidential identifier which you will place on the top of every page of your survey so that nobody can ever see your name connected to your answers.

_____	_____	_____ _____	_____ _____	_____
What is the *first* letter of your first name	**What is the *last* letter of your last name**	**What is the month of your birthday** **(For January through September use a leading "0" e.g. 01 for January)**	**What is the day of your birthday** **(For days 1 - 9 use a leading "0" e.g. 01)**	**What is the first letter of your mother's first name? (If you don't know, list the first letter of your father's first name)**

(01=Jan, 02=Feb, 03=Mar, 04=Apr, 05=May, 06=June, 07=July, 08=Aug, 09=Sept, 10=Oct, 11=Nov, 12=Dec)

Please copy the confidential ID you have created to the top right of each page of the survey.

Name of Interviewer: _____ Location of Interview: _____

Today's Date: _____ / ___ / ___ Interview Start Time: _____

Confidential ID: ____ ____ ____ ____ ____ ____ ____ ____

1. Are you currently **(Circle number next to the answer)**

HIV+ with disabling symptoms	1
HIV+ with no symptoms	2
HIV negative	3 → **Please see the interviewer.**

2. When were you born? ..... __ __ / __ __ __ __
Mo. **Year**.

3. Are you…

Male	1
Female	2
Transgender - Male to female (MTF)	3
Transgender - Female to male (FTM)	4

4. What do you consider your ethnic background?

African American (Black)	1
Other non-Hispanic Black	2
Latino/Hispanic	3
Asian Pacific Islander (API)	4
Native American	5
White/Caucasian (non Hispanic)	6
Mixed Race **(Specify)** _____	7
Other **(Specify)** _____	8

5. Do you consider yourself **(circle one)**

Heterosexual/Straight	1
Homosexual – Gay male	2
Homosexual – Lesbian	3
Bisexual	4
Other **(Specify)** _____	5

6. What is the highest level of education you completed?

Grade school or less	1
Some high school	2
Graduated high school/GED/trade school	3
Some college/2 year college degree	4
Completed 4 year college	5
Graduate level or professional study	6

GO TO QUESTION 7 AT TOP OF NEXT COLUMN

7. What is the zip code and city and/or neighborhood where you live?

__ __ __ __ __ **Zip** _____ **City and/or Neighborhood**

8 Where do you currently live? **(Circle one)**

In an apartment/house I own	1
In an apartment/house I rent	2
At my parent's/relative's apt./house	3
Living/crashing with someone & not paying rent	4
Single Room Occupancy (SRO)	5
In a "supportive living" /assisted living facility	7
In a group home or residence including residential drug therapy	8
In a half-way house or transitional housing	9
Skilled Nursing Home	10
Homeless (on the street/in car)	11
Homeless shelter	12
Jail or correctional facility	13
Hospital / Institution	14
Residential Hospice/Nursing Facility	15
Other **(Specify)** _____	16

9. Is your living situation …? **(Circle 1 for "Yes" or 2 for "No" for each item)**

	Yes	No
Safe	1	2
Habitable (clean and livable)	1	2
Stable	1	2

10. Do you…. **(Circle 1 for "Yes" or 2 for "No" for each item)**

	Yes	No
Live alone	1	2
Live with other adults **(write how many)**	__ #	2
Live with your children **(write how many)**	__ #	2

GO TO Q 11 AT BOTTOM OF PAGE

11. Over the last two (2) years, how long (total time) have you lived in each of the places listed below?

(Circle one answer for each of the items below)	Never	Less than a month	1-3 months	4 months to 1 yr.	More than 1 yr.
In a half-way house or transitional housing	1	2	3	4	5
In a treatment facility (drug or psychiatric)	1	2	3	4	5
Homeless (on the street/in car)	1	2	3	4	5
Homeless shelter	1	2	3	4	5
Jail or correctional facility	1	2	3	4	5
Other **(Specify)** _____	1	2	3	4	5

12. What best describes your current job (work) situation? **(Circle one)**

Employed full-time (33-40 hours a week)	1
Employed part-time (less than 33 hours a week)	2
Not working – looking for work	3
Not working – student /homemaker /other	4
Not working – not looking for work	5
Retired	6
Other **(Specify)** _____	7

13. What is your reported estimated **yearly** income from all sources and before taxes?

$0 to $ 8,600 (up to $716 a month)	1
$8,601 to $11,600 ($717 - $967 a month)	2
$11,601 to $16,500 ($968 - $1375 a month)	3
$16,501 to $23,200 ($1376 - $1933 a month)	4
$23,201 to $26,000 ($1934 - $2167 a month)	5
$26,001 to $35,000 ($2168 - $2917 a month)	6
Greater than $35,001 ($2918 or more a month)	7

14. Which of the following benefits do you receive?

(Circle 1 for "Yes", 2 for "No" or 8 for "Don't Know")	Yes	No	Don't Know
Food stamps	1	2	8
Long term disability	1	2	8
Short term disability	1	2	8
Supplemental Security Income (SSI)	1	2	8
Public Health Service, Bureau of Indian Affairs (BIA)	1	2	8
State Disability Insurance (SDI)	1	2	8
Social Security Disability Insurance (SSDI)	1	2	8
Veteran's benefits (VA)	1	2	8
CHAMPUS (VA Assistance for non-military personnel)	1	2	8
Worker's compensation	1	2	8
Annuity/Life insurance payments	1	2	8
Retirement	1	2	8
Rent supplement	1	2	8
Subsidized housing (HOPWA Subsidy, Section 8 certificate or Shelter Plus Care)	1	2	8
General Assistance (GA)	1	2	8
Emergency Financial Assistance	1	2	8
WIC	1	2	8
TANF/CalWORKS – formerly AFDC	1	2	8
Other **(Specify)** _____	1	2	8
Not eligible for benefits	1	2	8

15. What kind of health insurance do you have?

(Circle 1 for "Yes" or 2 for "No" for each item)	Yes	No
Insurance through work	1	2
COBRA or OBRA (insurance through my last employer)	1	2
Private insurance, not through work	1	2
Medicaid or MediCal	1	2
Medicare	1	2
Other Insurance **(Specify)**_____	1	2

16. **IF NO TO ALL OF THE ITEMS IN Q.15**, do you have any health insurance?

Yes **(Specify)** _____	1
No	2

17. What was the month and year that you first tested positive for HIV? __ __ **Mo.** _ _ _ _ **Year**

18. Where were you diagnosed as HIV positive?

_____ **City** _____ **State**

19. What is the most likely way you were infected by HIV? **(Circle one)**

Having sex with a man	1
Having sex with a woman	2
Having sex with a transgender	9
Sharing needles	3
Blood products/Transfusion (blood or tissue recipient)	4
Hemophilia	5
Acquired at birth	6
Other (**specify)**_____	7
Don't Know	8

20. Have you ever been told by your doctor, nurse, or other health care provider that you have AIDS?

Yes	1
No	2

20a. IF DIAGNOSED WITH AIDS, When were you diagnosed with AIDS? __ __ **Mo.** _ _ _ _ **Year**

21. Has your T-Cell count ….?

(Circle 1 for "Yes", 2 for "No" or 8 for "Don't Know")	Yes	No	Don't Know
Ever dropped below 500 cells/UL	1	2	8
Ever dropped below 350 cells/UL	1	2	8
Ever dropped below 200 cells/UL	1	2	8
Now dropped below 350 cells/UL	1	2	8
Now dropped below 200 cells/UL	1	2	8

22. Has your viral load ….?

(Circle 1 for "Yes", 2 for "No" or 8 for "Don't Know")	Yes	No	Don't Know
Ever rose above 30,000 copies ….	1	2	8
Ever rose above 10,000 copies ….	1	2	8
Currently above 10,000 copies…..	1	2	8

23. In general, would you say that today your physical health is…

Excellent 4
Good 3
Fair 2
Poor 1

24. How would you rate your physical health now as compared to when you first sought treatment for your HIV infection?

Much better 5
A little better 4
About the same 3
A little worse 2
Much worse 1

25. In general, would you say that today your emotional health is…

Excellent 4
Good 3
Fair 2
Poor 1

26. How would you rate your emotional health now as compared to when you first sought treatment for your HIV infection?

Much better 5
A little better 4
About the same 3
A little worse 2
Much worse 1

27. Check the box if you have never seen a doctor or gone to a clinic since you were diagnosed with HIV. **(GO TO Q.34)** ☐

28. What was the date of the last visit you had with a doctor for your HIV infection **(ESTIMATE IF NECESSARY)**? __ __ **Mo.** _ _ _ _ **Year**

29. Since you found out you were HIV positive,

(Circle 1 or "Yes" or 2 for "No" for each item)	Yes	No
Has there ever been a period of time of more than a **year (12 months)** when you didn't see a doctor or go to a clinic	**1**	**2**
Has there ever been a period of time of more than **six months** when you didn't see a doctor or go to a clinic?…..	**1**	**2**

30. If you stopped going to see a doctor, did you go back to see a doctor?

Yes ..... 1 **(GO TO Q.31)**
No ..... 2 **(GO TO Q.32)**

31. **IF YES TO Q.30**, What happened to make you seek medical care after not seeing a doctor or clinic professional for more than six months?

(Circle 1 or "Yes" or 2 for "No" for each item)	Yes	No
I got sicker	1	2
Change in my income	1	2
Change in my insurance status.....	1	2
Heard about new doctor / clinic	1	2
There was a change in my doctor's or clinic's attitudes	1	2
There were different drugs or treatments available	1	2
I had stable housing	1	2
Other **(specify)** _____	1	2

32. At any time in the last year, have you been diagnosed with any of the following diseases listed below?

(Circle 1 for "yes", 2 for "no" or 8 for "Don't Know)	Yes	No	Don't Know
Hepatitis A or B.....	1	2	8
Hepatitis C	1	2	8
Syphilis.....	1	2	8
Herpes (genital)	1	2	8
Gonorrhea	1	2	8
Chlamydia	1	2	8
Genital warts.....	1	2	8
Yeast infections.....	1	2	8
Other **(specify)** _____	1	2	8

33. Are you taking any of the following?

(Circle 1 for "Yes", 2 for "No" or 8 for DK)	Yes	No	Don't Know
Antiretrovirals and/or protease inhibitors.....	1	2	8
Antibiotics (such as Bactrim) that fight off infections.....	1	2	8

34. How often have you skipped taking your HIV/AIDS medication as prescribed by your doctor?

Never / Have not skipped **(Go to Q. 36)**	1
Once or twice a month	2
Once or twice a week	3
More than twice a week	4
I have stopped taking my medicine	5

35. If skipped or stopped taking your HIV/AIDS medication, why?

(Circle 1 for "Yes" or 2 for "No" for each item)	**Yes**	**No**
Side effects	1	2
Difficult schedule and requirements	1	2
Didn't want others to see the medications	1	2
Didn't understand the directions	1	2
Felt that medication didn't work	1	2
Could not afford medication	1	2
Forgot to take the medication	1	2
Ran out of medications	1	2
Hard to coordinate with food	1	2
Just did not want to take them	1	2
Homeless	1	2
Medication made me feel good so I felt I didn't need them anymore	1	2
My doctor advised me to stop taking my medications	1	2
Other **(specify)** _____	1	2

36. Since you were infected with HIV have you received mental health counseling or treatments?

Yes	1 → **Go to Q. 36a**
No	2 → **Skip to Q.37**

36a. Have you every received any of the following mental health counseling or treatments related to your HIV infection?

(Circle 1 for "Yes" or 2 for "No" for each item)	**Yes**	**No**
Inpatient (in a hospital at least overnight)	1	2
Individual counseling/therapy	1	2
Group counseling/therapy	1	2
Medication for psychological or behavioral problems	1	2

37. At any time in the last two years have you been diagnosed with any of the following mental health problems?

(Circle 1 or "Yes" or 2 for "No" for each item)	**Yes**	**No**
Anxiety	1	2
Bipolar Disorder	1	2
Dementia	1	2
Depression	1	2
Other **(specify)**_____	1	2

GO QUESTION 38 TOP OF NEXT PAGE

38. For each of the services below:

1. Under column A, note if you *needed* the service in the past year. Circle "1"for yes or "2" for no.
2. Under column B, note whether you *asked* for this service this past year.
3. Under column C, note if you *received* this service this past year.

	For each service below…	A: Have you *needed* this service this past year?		B: Have you asked for this service this past year?		C: Have you *received* this service this past year?	
MEDICAL CARE		**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
1	Visits with a doctor, nurse, or assistant to take care of your on-going HIV treatment – Outpatient medical care.	1	2	1	2	1	2
2	Medical care by a specialist, including OB/GYN	1	2	1	2	1	2
3	Nutritional supplements, education, and counseling.	1	2	1	2	1	2
4	Dental care.	1	2	1	2	1	2
5	Home heath care from a nurse or aide.	1	2	1	2	1	2
6	Hospice Services (In-home and residential)	1	2	1	2	1	2
7	Complementary care – includes acupuncture and traditional Chinese medicine.	1	2	1	2	1	2
8	Medication programs including ADAP that provides assistance obtaining and paying for HIV/AIDS related drugs.	1	2	1	2	1	2
9	IF YOU HAVE PRIVATE HEALTH INSURANCE, assistance paying health insurance premiums.	1	2	1	2	1	2

TRANSPORTATION		**Need it**		**Ask for it**		**Receive it**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
10	Van transportation to HIV/AIDS services.	1	2	1	2	1	2
11	Taxi vouchers or bus tokens.	1	2	1	2	1	2

MENTAL HEALTH & SUBSTANCE ABUSE SERVICES		**Need it**		**Ask for it**		**Receive it**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
12	Residential mental health services.	1	2	1	2	1	2
13	Individual or groups mental health therapy or counseling sessions by a psychiatrist, psychologist, or social worker	1	2	1	2	1	2
14	Peer counseling, support, or drop-in groups.	1	2	1	2	1	2
15	Outpatient substance abuse treatment or counseling.	1	2	1	2	1	2
16	24 hour-a-day residential substance abuse counseling.	1	2	1	2	1	2
17	Detox and / or methadone maintenance.	1	2	1	2	1	2

	For each service below…	A: Have you *needed* this service this past year?		B: Have you asked for this service this past year?		C: Have you *received* this service this past year?	
CASE MANAGEMENT		**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
18	Medical case management and adherence support from a nurse or care provider	1	2	1	2	1	2
19	Case Manager (not a doctor or nurse) who helps you obtain treatment, medications, financial assistance, and benefits and assures coordinated access to care.	1	2	1	2	1	2
20	Employment Assistance – vocational counseling and training.	1	2	1	2	1	2

HOUSING		**Need it**		**Ask for it**		**Receive it**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
21	Housing information services – assistance in finding or getting housing.	1	2	1	2	1	2
22	Rental subsidy (NOT emergency financial assistance)	1	2	1	2	1	2
23	"Independent" housing provided through Section 8, HOPWA, or other state agency that has no on-site medical or case management	1	2	1	2	1	2
24	Residential housing or group home where there is 24 hour support such as case management or nursing.	1	2	1	2	1	2
25	Emergency or transitional housing for those who are homeless and in need of immediate housing.	1	2	1	2	1	2

FOOD		**Need it**		**Ask for it**		**Receive it**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
26	Food pantry or food bank	1	2	1	2	1	2
27	Food vouchers.	1	2	1	2	1	2
28	Home delivered meals.	1	2	1	2	1	2

OTHER SERVICES		**Need it**		**Ask for it**		**Receive it**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
29	Prevention information and education on how to prevent the spread of HIV.	1	2	1	2	1	2
30	Emergency financial assistance, usually to pay rent, utilities, food, and clothing.	1	2	1	2	1	2
31	Legal services – preparing wills or estate planning; assistance with evictions and housing discrimination.	1	2	1	2	1	2
32	Adult day care.	1	2	1	2	1	2
33	Day care for children during a care givers appointment for HIV/AIDS care.	1	2	1	2	1	2

39. Below is a list of problems that you may have had when trying to obtain or use HIV/AIDS services. Mark an X on the line beside each item to say how big a problem it has been for you. The line goes from a "very big" to a "very small" problem. A "very big" problem means that it stopped you from getting the service(s). A "moderate" problem means that you faced substantial problems but that you were able to get the service most of the time. A "very small" problem caused you minor concern and delays in obtaining the service(s). If you have not had the problem at all, circle "0".

Very Big = it stopped you from getting the service Moderate = you faced substantial problems but were able to get the service Very Small = caused you minor concern and delays in obtaining the service	**Very Big**	**Big**	**Mod-erate**	**Small**	**Very Small**	**Not a problem**
Example: The survey is difficult to complete					X	0
a. Not knowing that a service or treatment was available to me.						0
b. Not knowing a location of the service(s).						0
c. My physical health has not allowed me to get to the place where the service is provided.						0
d. I do not believe HIV or AIDS is a problem for me that requires assistance.						0
e. Not knowing what medical services I need to treat my HIV infection or AIDS.						0
f. My state of mind or mental ability to deal with the treatment.						0
g. Not understanding the instructions for obtaining the service or treatment.						0

	Very Big	**Big**	**Mod-erate**	**Small**	**Very Small**	**Not a problem**
h. Not knowing who to ask for help.						0
i. Sensitivity of the organization and person providing services to me regarding my issues and concerns.						0
j. Discrimination I experienced by the persons or organization providing the services.						0
k. Experience or expertise of the person providing services to me.						0
l. The amount of time I had to wait to get an appointment or to see someone.						0
m. The organization providing the service made me feel like a number.						0
n. I do not get along with people providing services						0

39. (continued) Below is a list of problems that you may have had when trying to obtain or use HIV/AIDS services. Mark an X on the line beside each item to say how big a problem it has been for you. The line goes from a "very big" to a "very small" problem.

Very Big = it stopped you from getting the service Moderate = you faced substantial problems but were able to get the service Very Small = caused you minor concern and delays in obtaining the service	**Very Big**	**Big**	**Mod-erate**	**Small**	**Very Small**	**Not a problem**
o. I have been denied or have been afraid to seek services due to a criminal justice matter.	____|____|____|____|____					0
p. My ability to communicate or interact with the service provider.	____|____|____|____|____					0
q. The people providing services to me are not helpful.	____|____|____|____|____					0
r. The organization did not provide the right referrals to the services I need.	____|____|____|____|____					0
s. My ability to find my way through the system.	____|____|____|____|____					0
t. There was no specialist who could provide the care I needed.	____|____|____|____|____					0
u. Fear of my HIV or AIDS status being found out by others – lack of confidentiality.	____|____|____|____|____					0

	Very Big	**Big**	**Mod-erate**	**Small**	**Very Small**	**Not a problem**
v. Fear that I would be reported to immigration or other authorities.	____|____|____|____|____					0
w. No transportation.	____|____|____|____|____					0
x. No childcare.	____|____|____|____|____					0
y. I was not eligible for the service.	____|____|____|____|____					0
z. There was too much paperwork or red tape.	____|____|____|____|____					0
aa. I can't afford one or more of the service.	____|____|____|____|____					0
bb. There are too many rules and regulations.	____|____|____|____|____					0
cc. My lack of, or inadequate, insurance coverage.	____|____|____|____|____					0
dd. I have been terminated or suspended from seeking services	____|____|____|____|____					0
ee. Other _____	____|____|____|____|____					0

40. During the past year, how often have you used any of the following substances?

	Not used in last year	Used in the past 6 months	Used less than once a month	Used at least once a month	Used once a week or more
Alcohol	1	2	3	4	5
Marijuana or hash	1	2	3	4	5
Crack / Cocaine	1	2	3	4	5
Heroin	1	2	3	4	5
Crystal Meth or Methamphetamines	1	2	3	4	5
Speedball	1	2	3	4	5
GHB (Gamma Hydroxybutyrate)	1	2	3	4	5
Poppers	1	2	3	4	5
Ecstasy (X)	1	2	3	4	5
Pills not prescribed by my doctor **(specify)**_____	1	2	3	4	5
Other substances **(specify)** _____	1	2	3	4	5

41. **IF YOU HAVE USED ANY SUBSTANCES,** Have you ever injected any substances not prescribed by a medical person?

Yes 1
No 2

42. **IF YOU HAVE INJECTED SUBSTANCES,** How many times have you shared needles with someone in the past year?

Write Number of times _____

43. Where were you born?

The United States **(IF BORN IN THE US, GO TO Q46 NEXT PAGE)** 1
Mexico 2
Puerto Rico or other US Territories 3
Central America 4
China 5
Other **(specify)** _____ 6

44 **IF NOT BORN IN THE UNITED STATES,** in what year did you first come to the United States? _____ **Year**

45. How would you describe your residency status in the United States?

Citizen 1
Have a visa (student, temp or permanent) 2
Have legal refugee or asylum status 3
Undocumented 4

Other **(specify)** _____ 5

46. **(Optional)** Before we finish this survey, do you have any other comments about your satisfaction with the way you get HIV or AIDS related services? **If not enough space, please continue your comments on the other side.**

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Interview End Time: _____

Mode of transmission (Q18)

MSM	1
IDU	2
Heterosexual Transmission	3
MSM/IDU	4
Adult Hemophiliac/blood products	5
Don't Know (DK)	8

Race/Ethnicity (Q4)

White	1
African American	2
Hispanic/Latino	3
Asian/Pacific Islander	4
Native American/Alaskan Native	5
Mixed Race	6

Gender (Q3)

Man	1
Woman	2
Transgender	3

Interviewer Asst Initials.....

Seq. Identifier.....

SPA

SPA1	01	SPA4	04	SPA7	07
SPA2	02	SPA5	05	SPA8	08
SPA3	03	SPA6	06		

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Attachment 3 Service Planning Area (SPA) Descriptions

SPA1: Antelope Valley

SPA 1-Antelope Valley-is located about 60 miles north of downtown Los Angeles and covers approximately 2,500 square miles of desert, forest and rural area. It extends north to the Kern County line and east to San Bernardino County line. The Angeles National Forest (Highway 117) forms the SPA's southern border. Its western border includes the Ventura County line, and a boundary line running south through the Angeles National Forest, east of Lake Elizabeth and Green Valley, to the Sierra Highway along Sand Canyon Road, through a portion of the City of Santa Clarita to Little Tujunga Road on the South. Its largest cities are Lancaster, Palmdale and Santa Clarita.

SPA 2: San Fernando Valley

SPA 2-San Fernando Valley-is a large suburban area north of the Los Angeles basin that includes sizable portions of the Angeles National Forest. Its eastern boundary runs through the forest northwest of Lake Elizabeth, and extends along Sand Canyon Road through the eastern portion of the City of Santa Clarita. The border continues east along Highway 117, down Angeles Forest Highway, west to a line south of Big Tujunga Canyon Road, then south again along the border of the City of Pasadena. SPA 2's western border is the Ventura County line. Its southern border runs parallel to the city limits of Glendale and Burbank along Mulholland Drive and Mulholland Highway, through state parkland and the Santa Monica Mountains. Its largest cities are Burbank, Glendale and sizable portion of the City of Los Angeles.

SPA 3: San Gabriel Valley

SPA 3-San Gabriel Valley-is one of the largest County geographic regions in terms of land area, second only to the Antelope Valley (SPA 1). SPA 3 is situated between the San Gabriel Mountains to the north and the Whittier Hills to the south. The foothills are dotted with a number of independent cities such as Glendora, Sierra Madre, San Dimas, La Verne, Pasadena and Claremont. The SPA's western border is defined by the western boundaries of the cities of Pasadena, South Pasadena, Alhambra and Monterey Park. Its eastern boundary is the San Bernardino County line, contiguous with the city boundaries of Claremont, Pomona and Diamond Bar. SPA 3's southern border runs below a series of unincorporated areas (Whittier Narrows, Hacienda Heights, Rowland Heights) and the Orange County line. Pasadena, the largest city in SPA 3, is also its own health district.

SPA 4: Metro

SPA 4-Metro-is located in the geographic center of the County. It shares boundaries with all but two of the eight County SPAs (SPA 1-Antelope Valley and SPA 8-South Bay-Long Beach). Its northern border touches the SPA 2 communities of Glendale and Burbank in an area generally parallel to the Ventura (134) Freeway. Its southern border runs along Washington Boulevard,

beginning at La Cienega Boulevard to the Harbor (110) Freeway, then south to Adams Boulevard and east to Hooper, and north again to 21stt Street and 25th Street (the northern border of the City of Vernon) to Indiana Street, which is the Los Angeles City limit.

The SPA's eastern boundary abuts SPA 3 and SPA 7, following the Los Angeles City limit on Indiana Street from the City of Vernon, separating the community of Boyle Heights from East Los Angeles in SPA 7. Proceeding north to Valley Boulevard, the boundary extends further east to include the campus of California State University, Los Angeles, adjacent to the Long Beach (710) and San Bernardino (10) freeways. The border continues north along the boundaries of the cities of Alhambra, South Pasadena, and Pasadena.

SPA 4's western border is a jagged line that begins in the south on La Cienega Boulevard at Washington Boulevard, travels north and then east along the boundary separating the City of Beverly Hills from the cities of Los Angeles and West Hollywood, along Wonderland Avenue and Mulholland Drive, turning a bit east to the Hollywood (101) Freeway, then north again along Barham Boulevard, east of Universal Studios, to the city limits of Burbank. One of the busiest traffic centers of the County is the four-level freeway interchange in Downtown Los Angeles that conducts traffic in all directions along the 5, 110, 10, and Hollywood 101 Freeways.

The city of West Hollywood and the xxxx of Hollywood, due to the prevalence and size of their gay male population, all generally considered the epicenter of the epidemic in Los Angeles County. SPA 4 encompasses the Los Angeles communities of Downtown LA (where the largest congregation of homeless and immigrant workers can be found), Pico-Union (where there is a large undocumented population), and Silver Lake/Los Feliz/Echo Park (where there are large gay populations).

SPA 5: West

SPA 5-West-includes state-owned land, portions of the Santa Monica Mountains National Recreation Area, coastline, state beaches, marinas and the Los Angeles International Airport (LAX). Its western border is the Ventura County line. Its eastern boundary runs south along Laurel Canyon Boulevard, Doheny Drive, the eastern border of Culver City and La Cienega Boulevard through the western side of Baldwin Hills and Ladera Heights to Imperial Highway. The northern border follows a number of mountain roads beginning with Mulholland Highway on the west, through state parklands, up the western border of Topanga State Park, and along Mulholland Drive to the east. The coastline, reaching from Carrillo State Beach to El Segundo, forms the SPA's southern boundary. Overall, SPA 5 is the highest income area of Los Angeles County.

SPA 6: South

SPA 6-South-stretches from Washington Boulevard on the north to Artesia Boulevard (the 91 Freeway) on the south, and has irregular boundary lines. On the north, SPA 6 borders Los Angeles City communities such as Mid-City, Country Club Park, Pico Union, and Koreatown. The southeastern tip of Downtown Los Angeles and the city boundaries of Vernon, Huntington Park, South Gate, Downey, and Bellflower form the SPA's eastern border. Southern borders

align with the city boundaries of Carson and Long Beach, and the unincorporated area of Rancho Dominguez; the southern tip of Compton extends into SPA 8 (South Bay/Harbor). SPA 6's western boundary proceeds along the borders of the neighboring cities of Inglewood and Culver City, extending south and east along portions of La Cienega Boulevard, Fairfax Avenue, Van Ness Avenue, Vermont Avenue, and Figueroa Street. The Harbor (110) and Santa Monica (10) Freeways are major north-south and east-west arteries crossing the SPA. SPA 6 has the highest proportion of communities of color of any of the SPA. Historically a predominantly African American area, it has witnessed an influx of Latinos over the past two decades—which now represents the majority of the population in the SPA.

SPA 7: East

SPA 7-East-is situated south of San Gabriel Valley and east of central Los Angeles. Its northern border runs along the boundaries of unincorporated East Los Angeles, the cities of Montebello, Pico Rivera, and La Habra Heights, and the Puente Hills. The SPA's southeast boundary is the dividing line between Los Angeles and Orange Counties. Its western border is defined by portions of the western limits of the cities of Lakewood, Bellflower, Downey, South Gate, Huntington Park, and Vernon, and the unincorporated areas of Walnut Park and East Los Angeles. Since the County's Service Planning Areas were designed around County Health Districts, the City of Signal Hill (adjacent to but not part of the Long Beach health district) is also included in SPA 7.

SPA 8: South Bay-Long Beach

SPA 8-South Bay/Long Beach-is a mosaic of communities, ports, and incorporated municipalities, including the corridor that links the City of Los Angeles to all major ports of entry for international trade.

The coastline along the Pacific Ocean serves as the western and southern border of SPA 8, from the City of El Segundo to the north, around the Palos Verdes Peninsula to the Los Angeles and Long Beach Harbors on the south. The SPA includes Santa Catalina Island and its xxxxx. The eastern boundaries of the City of Long Beach, generally parallel to the San Gabriel River, constitute the eastern border for SPA 8. Its northern boundary is a jagged line that runs from 64th Street in the City of Inglewood-at the northernmost tip of the region-to Figueroa Street, south to the Artesia Highway (91), and east along the northern border of the City of Long Beach to 70th Street. Long Beach is by far the largest city in the SPA, and one of the largest in the State—constituting its own health district. Long Beach hosts a sizable gay community, and various communities of color are predominant in various municipalities through out the region.

Attachment 4 Formula for Estimating PLWH/A

Absent a system of HIV reporting, Los Angeles County has chosen to use its own estimates of HIV prevalence for the purposes of the Comprehensive Care Plan. The estimates developed by the Centers for Disease Control and Prevention and provided by HRSA seem to under-represent key subpopulations of HIV/AIDS cases in Los Angeles County. The CDC/HRSA estimates were developed using the ratio between known AIDS cases and known HIV cases in states with HIV reporting. Overall, those states have a distribution of AIDS cases distinctly different from that of Los Angeles County, as well as distinctly different general populations. Key among those differences are that Los Angeles County has a higher proportion of AIDS cases associated with male-to-male sex, a larger and more diverse population of gay and bisexual men, a higher number and proportion of AIDS cases among Latino/as, a much larger general population of Latino/as, and a much smaller IDU HIV/AIDS than experienced nationally and generally, in states with HIV reporting.

The Los Angeles County HIV Epidemiology Program estimated HIV prevalence using the same general methodology as the CDC, but applied it to known ratios of HIV to AIDS cases in the more narrow range of states (Arizona, Colorado and Texas) whose populations most closely resemble those of Los Angeles County.

The ratio of 1.6 HIV (non-AIDS) case to every 1 reported AIDS case, derived from the Arizona, Colorado and Texas data, is consistent with the data gathered in the HIV/AIDS Reporting Surveillance System (HARS), the Los Angeles County HIV counseling and testing results from the past two years and the ratio of HIV/AIDS status of clients in three sentinel clinics in Los Angeles County (AIDS Healthcare Foundation, AltaMed Health Services and the Jeffrey Goodman Special Care Clinic of the Los Angeles Gay and Lesbian Center). That ratio used for the Los Angeles County estimates is at the low end of the estimates developed by a statewide working group.

Known AIDS cases at the end of 2001 were 16,663, based on HARS. This is multiplied by 1.6, based on the estimated proportion of AIDS to HIV cases derived above. The total number of PLWH/A who know their status would be 43,280. CDC estimates that about a third of the HIV positives don't know their HIV+ status, and suggesting that 8,789 persons in Los Angeles County do not know their status, resulting in a total number of PLWH/A in the environment of 52,069.

Attachment 5 Poverty Levels

2001 Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia						
Number in Family	Gross Yearly Income	Gross Monthly Income*	Approximate Hourly Income**	200%	300%	400%
1	$8,590	$716	$4.13	$17,180	$25,770	$34,360
2	$11,610	$968	$5.58	$23,220	$34,830	$46,440
3	$14,630	$1,219	$7.03	$29,260	$43,890	$58,520
4	$17,650	$1,471	$8.49	$35,300	$52,950	$70,600
5	$20,670	$1,723	$9.94	$41,340	$62,010	$82,680
6	$23,690	$1,974	$11.39	$47,380	$71,070	$94,760
7	$26,710	$2,226	$12.84	$53,420	$80,130	$106,840
8	$29,730	$2,478	$14.29	$59,460	$89,190	$118,920
Over 8, add for each child	$3,020	$252	$1.45	$6,040	$9,060	$12,080

Attachment 6 2002 Survey - Demographics

Attachment 6 2002 Survey Demographics																				
	Total	GENDER			ETHNICITY					RISKGRP							STAGE OF INFECTION			
	Sample	Male	Female	TG	Af Am	Anglo	API	Latino	Native Am	MSM Total	Af Am MSM	Anglo MSM	Latino MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
	246	**170**	**72**	**4**	**74**	**63**	**17**	**80**	**5**	**98**	**26**	**26**	**34**	**35**	**30**	**83**	**58**	**40**	**39**	**90**
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Serostatus																				
HIV+ with disabling symptoms	57.0	58.2	53.0	75.0	52.2	58.7	68.8	59.2	50.0	63.0	52.0	61.5	73.3	58.8	46.4	52.7	0.0	100.0	0.0	100.0
HIV+ with no symptoms	43.0	41.8	47.0	25.0	47.8	41.3	31.3	40.8	50.0	37.0	48.0	38.5	26.7	41.2	53.6	47.3	100.0	0.0	100.0	0.0
AGE (mean value)	42.7	44.4	38.9	38.1	44.0	45.1	47.1	39.1	44.9	45.2	45.7	50.0	41.4	41.9	43.5	39.9	41.6	41.9	41.9	44.4
AGEGROUP																				
13-19	1.3	0.6	3.0	0.0	0.0	0.0	0.0	3.9	0.0	1.1	0.0	0.0	3.0	0.0	0.0	2.6	3.8	0.0	2.6	0.0
20-24	1.7	0.6	4.5	0.0	1.5	1.6	0.0	2.6	0.0	0.0	0.0	0.0	0.0	2.9	0.0	3.8	1.9	2.6	0.0	2.3
25-54	87.2	87.8	85.1	100.0	88.2	85.7	75.0	89.6	75.0	83.9	87.5	69.2	90.9	91.4	96.6	85.9	84.9	92.1	87.2	85.2
55+	9.8	11.0	7.5	0.0	10.3	12.7	25.0	3.9	25.0	15.1	12.5	30.8	6.1	5.7	3.4	7.7	9.4	5.3	10.3	12.5
Gender																				
Male	69.1	100.0	0.0	0.0	54.1	88.9	76.5	62.5	100.0	96.9	96.2	100.0	94.1	100.0	70.0	22.9	69.0	57.5	65.0	76.7
Female	29.3	0.0	100.0	0.0	43.2	11.1	23.5	35.0	0.0	0.0	0.0	0.0	0.0	0.0	26.7	77.1	29.3	42.5	35.0	20.0
Transgender - MTF	1.2	0.0	0.0	75.0	1.4	0.0	0.0	2.5	0.0	3.1	3.8	0.0	5.9	0.0	0.0	0.0	1.7	0.0	0.0	2.2
Transgender - FTM	0.4	0.0	0.0	25.0	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.3	0.0	0.0	0.0	0.0	1.1
Ethnicity																				
African American (Black)	30.2	23.7	44.4	50.0	100.0	0.0	0.0	0.0	0.0	26.5	100.0	0.0	0.0	14.7	23.3	43.4	37.9	35.0	25.6	23.3
Latino / Hispanic	32.7	29.6	38.9	50.0	0.0	0.0	0.0	100.0	0.0	34.7	0.0	0.0	100.0	8.8	26.7	42.2	32.8	30.0	25.6	33.3
Asian / Pacific Islander (API)	6.9	7.7	5.6	0.0	0.0	0.0	100.0	0.0	0.0	8.2	0.0	0.0	0.0	5.9	0.0	8.4	3.4	2.5	7.7	11.1
Native American	2.0	3.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	2.0	0.0	0.0	0.0	2.9	6.7	0.0	3.4	0.0	0.0	2.2
White / Caucasian (non Hispanic)	25.7	33.1	9.7	0.0	0.0	100.0	0.0	0.0	0.0	26.5	0.0	100.0	0.0	61.8	40.0	4.8	19.0	32.5	38.5	26.7
Mixed Race	1.6	1.8	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	5.9	3.3	1.2	3.4	0.0	2.6	1.1
Other	0.8	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.2
Sexual orientation																				
Heterosexual/Straight	42.4	22.8	88.9	25.0	52.1	22.6	43.8	50.0	40.0	1.0	0.0	0.0	2.9	0.0	85.7	94.0	50.0	47.5	46.2	30.0
Homosexual - Gay male	40.7	58.1	0.0	50.0	28.8	58.1	43.8	38.8	20.0	74.2	65.4	80.8	82.4	77.1	0.0	0.0	31.0	27.5	35.9	55.6
Homosexual - Lesbian	2.1	0.0	6.9	0.0	1.4	0.0	0.0	5.0	0.0	0.0	0.0	0.0	0.0	0.0	7.1	3.6	1.7	2.5	5.1	1.1
Bisexual	13.6	18.0	2.8	25.0	16.4	19.4	12.5	6.3	20.0	22.7	34.6	19.2	14.7	22.9	7.1	1.2	17.2	20.0	12.8	11.1
Other	1.2	1.2	1.4	0.0	1.4	0.0	0.0	0.0	20.0	2.1	0.0	0.0	0.0	0.0	0.0	1.2	0.0	2.5	0.0	2.2
Highest level of education																				
Grade school or less	9.4	7.1	15.3	0.0	1.4	3.2	17.6	21.3	0.0	7.1	3.8	0.0	11.8	0.0	13.8	14.5	8.6	7.5	12.5	3.3
Some high school	19.2	14.2	29.2	50.0	20.5	11.1	5.9	27.5	40.0	7.1	3.8	3.8	14.7	14.3	34.5	30.1	20.7	20.0	2.5	23.3
Graduated High School/GED/trade school	29.8	29.6	31.9	0.0	34.2	31.7	5.9	26.3	20.0	26.5	19.2	26.9	32.4	31.4	31.0	32.5	24.1	40.0	40.0	26.7
Some College / 2 year college degree	29.0	33.7	16.7	50.0	32.9	34.9	52.9	17.5	20.0	39.8	57.7	34.6	26.5	37.1	20.7	15.7	34.5	22.5	27.5	33.3
Completed 4 year College	6.1	7.1	4.2	0.0	6.8	4.8	11.8	3.8	20.0	7.1	7.7	7.7	5.9	11.4	0.0	4.8	3.4	5.0	7.5	7.8
Graduate Level	6.5	8.3	2.8	0.0	4.1	14.3	5.9	3.8	0.0	12.2	7.7	26.9	8.8	5.7	0.0	2.4	8.6	5.0	10.0	5.6
Where do you currently live?																				
In my own apartment/house I own	8.5	7.3	11.8	0.0	8.7	14.5	6.7	5.1	0.0	9.7	0.0	20.0	9.1	8.6	0.0	10.1	8.8	12.5	7.9	7.1
In my own apartment/house I rent	63.6	61.8	66.2	100.0	59.4	59.7	66.7	67.9	80.0	64.5	58.3	68.0	69.7	51.4	62.1	68.4	50.9	47.5	73.7	75.3
At my parent's/relative's apt./house	7.6	7.9	7.4	0.0	5.8	1.6	6.7	14.1	0.0	4.3	0.0	0.0	9.1	11.4	6.9	10.1	12.3	5.0	7.9	4.7
Crashing w/ someone w/out paying rent	3.4	4.2	1.5	0.0	4.3	4.8	6.7	1.3	0.0	4.3	12.5	0.0	0.0	8.6	3.4	0.0	5.3	5.0	2.6	2.4
SRO	3.0	2.4	4.4	0.0	7.2	1.6	0.0	1.3	0.0	3.2	12.5	0.0	0.0	0.0	3.4	3.8	3.5	7.5	5.3	0.0
In a "supportive living" facility	2.5	3.0	1.5	0.0	1.4	3.2	6.7	1.3	20.0	3.2	0.0	4.0	3.0	2.9	3.4	1.3	3.5	2.5	0.0	3.5
Group home/residence (e.g residential drug tx)	4.2	4.8	2.9	0.0	5.8	6.5	0.0	2.6	0.0	3.2	8.3	0.0	3.0	11.4	6.9	1.3	5.3	12.5	0.0	1.2
In a half-way house or transitional housing	3.0	3.6	1.5	0.0	1.4	4.8	0.0	2.6	0.0	4.3	0.0	8.0	3.0	5.7	0.0	1.3	3.5	2.5	0.0	4.7
Skilled nursing home	0.8	1.2	0.0	0.0	0.0	0.0	6.7	1.3	0.0	1.1	0.0	0.0	3.0	0.0	0.0	1.3	0.0	2.5	0.0	1.2
Homeless (on the street/in car)	1.3	1.8	0.0	0.0	1.4	1.6	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	6.9	1.3	1.8	2.5	0.0	0.0
Homeless shelter	1.3	1.2	1.5	0.0	2.9	1.6	0.0	0.0	0.0	1.1	4.2	0.0	0.0	0.0	3.4	1.3	1.8	0.0	2.6	0.0
Jail or correctional facility	0.4	0.0	1.5	0.0	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	3.4	0.0	1.8	0.0	0.0	0.0
Other	0.4	0.6	0.0	0.0	1.4	0.0	0.0	0.0	0.0	1.1	4.2	0.0	0.0	0.0	0.0	0.0	1.8	0.0	0.0	0.0
Living situation safe	91.6	92.3	93.0	33.3	84.1	96.7	100.0	94.3	75.0	91.4	82.6	95.8	95.8	97.0	92.6	88.7	84.9	94.3	97.1	93.0
Living situation habitable	92.4	95.1	88.5	33.3	92.6	95.2	100.0	90.0	75.0	93.8	94.7	92.3	96.4	97.1	83.3	91.4	88.2	93.8	93.9	94.3
Living situation stable	86.5	89.4	82.0	33.3	81.5	88.3	100.0	85.7	100.0	90.5	83.3	95.8	91.7	84.4	79.2	85.5	87.0	79.4	96.9	86.4
Live alone	47.4	56.9	20.4	50.0	52.6	52.4	46.2	38.5	75.0	71.6	63.6	73.1	79.3	33.3	37.0	24.6	40.0	45.7	40.0	59.7

Attachment 6 2002 Survey Demographics																				
	Total	GENDER			ETHNICITY					RISKGRP							STAGE OF INFECTION			
	Sample	Male	Female	TG	Af Am	Anglo	API	Latino	Native Am	MSM Total	Af Am MSM	Anglo MSM	Latino MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
	246	**170**	**72**	**4**	**74**	**63**	**17**	**80**	**5**	**98**	**26**	**26**	**34**	**35**	**30**	**83**	**58**	**40**	**39**	**90**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
# of other adults living at home																				
One other adult	49.1	43.7	57.1	100.0	45.2	57.1	66.7	41.0	50.0	25.0	22.2	28.6	14.3	65.2	52.9	54.3	44.8	44.4	66.7	55.3
2-3 other adults	31.6	31.0	33.3	0.0	35.5	21.4	22.2	38.5	50.0	35.7	55.6	42.9	14.3	13.0	29.4	39.1	37.9	16.7	27.8	31.6
4+ other adults	19.3	25.4	9.5	0.0	19.4	21.4	11.1	20.5	0.0	39.3	22.2	28.6	71.4	21.7	17.6	6.5	17.2	38.9	5.6	13.2
# of children living at home	9.9	0.0	15.9	0.0	16.7	0.0	0.0	10.7	0.0	0.0				0.0	0.0	15.2				
One child at home	39.4	33.3	43.2	0.0	41.7	41.7	50.0	35.7	0.0	33.3	60.0	0.0	0.0	28.6	55.6	39.1	35.0	33.3	33.3	55.0
2-3 children	50.7	66.7	40.9	0.0	41.7	58.3	50.0	53.6	0.0	66.7	40.0	100.0	100.0	71.4	44.4	45.7	55.0	66.7	58.3	35.0
4+ children	9.9	0.0	15.9	0.0	16.7	0.0	0.0	10.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	15.2	10.0	0.0	8.3	10.0
Time in half-way/transitional housing																				
Never	82.1	81.8	83.3	75.0	85.1	84.1	94.1	77.5	60.0	84.7	84.6	92.3	79.4	71.4	90.0	80.7	86.2	65.0	87.5	86.7
Less than a month	2.4	2.9	1.4	0.0	0.0	3.2	0.0	3.8	20.0	1.0	0.0	0.0	2.9	11.4	0.0	1.2	1.7	2.5	0.0	3.3
1-3 months	4.9	6.5	1.4	0.0	4.1	7.9	0.0	2.5	0.0	4.1	3.8	3.8	2.9	8.6	6.7	3.6	5.2	17.5	2.5	1.1
4 months to 1 yr.	6.1	4.7	8.3	25.0	5.4	3.2	5.9	8.8	20.0	5.1	3.8	0.0	8.8	5.7	3.3	8.4	3.4	5.0	7.5	5.6
More than 1 yr.	4.5	4.1	5.6	0.0	5.4	1.6	0.0	7.5	0.0	5.1	7.7	3.8	5.9	2.9	0.0	6.0	3.4	10.0	2.5	3.3
Time homeless (on the street/in car)?																				
Never	86.2	82.9	93.1	100.0	89.2	79.4	100.0	88.8	80.0	90.8	88.5	92.3	91.2	65.7	70.0	95.2	79.3	82.5	92.5	86.7
Less than a month	4.1	5.3	1.4	0.0	4.1	6.3	0.0	2.5	0.0	3.1	7.7	0.0	2.9	14.3	0.0	2.4	10.3	2.5	0.0	3.3
1-3 months	4.1	4.1	4.2	0.0	2.7	6.3	0.0	5.0	0.0	2.0	0.0	3.8	2.9	8.6	10.0	2.4	1.7	5.0	7.5	4.4
4 months to 1 yr.	3.3	4.1	1.4	0.0	1.4	4.8	0.0	2.5	20.0	2.0	0.0	0.0	2.9	11.4	6.7	0.0	3.4	7.5	0.0	3.3
More than 1 yr.	2.4	3.5	0.0	0.0	2.7	3.2	0.0	1.3	0.0	2.0	3.8	3.8	0.0	0.0	13.3	0.0	5.2	2.5	0.0	2.2
Time in a homeless shelter																				
Never	88.6	89.4	87.5	75.0	87.8	90.5	100.0	86.3	100.0	88.8	84.6	96.2	85.3	82.9	86.7	91.6	84.5	75.0	95.0	93.3
Less than a month	5.7	7.1	2.8	0.0	6.8	7.9	0.0	2.5	0.0	7.1	11.5	3.8	5.9	8.6	6.7	2.4	5.2	17.5	0.0	4.4
1-3 months	2.4	2.4	1.4	25.0	2.7	1.6	0.0	3.8	0.0	3.1	3.8	0.0	5.9	5.7	0.0	1.2	6.9	2.5	2.5	0.0
4 months to 1 yr.	1.6	0.6	4.2	0.0	1.4	0.0	0.0	3.8	0.0	0.0	0.0	0.0	0.0	2.9	3.3	2.4	1.7	0.0	0.0	2.2
More than 1 yr.	1.6	0.6	4.2	0.0	1.4	0.0	0.0	3.8	0.0	1.0	0.0	0.0	2.9	0.0	3.3	2.4	1.7	5.0	2.5	0.0
Time in a jail or correctional facility																				
Never	83.7	79.4	94.4	75.0	82.4	79.4	100.0	88.8	60.0	82.7	73.1	88.5	82.4	71.4	70.0	95.2	75.9	70.0	95.0	87.8
Less than a month	2.4	2.9	0.0	25.0	0.0	4.8	0.0	2.5	0.0	5.1	0.0	11.5	5.9	0.0	3.3	0.0	3.4	5.0	2.5	1.1
1-3 months	3.7	4.7	1.4	0.0	2.7	7.9	0.0	1.3	20.0	3.1	7.7	0.0	2.9	11.4	6.7	0.0	1.7	10.0	0.0	4.4
4 months to 1 yr.	5.7	7.1	2.8	0.0	6.8	6.3	0.0	5.0	0.0	6.1	7.7	0.0	8.8	11.4	6.7	2.4	6.9	15.0	0.0	4.4
More than 1 yr.	4.5	5.9	1.4	0.0	8.1	1.6	0.0	2.5	20.0	3.1	11.5	0.0	0.0	5.7	13.3	2.4	12.1	0.0	2.5	2.2
Homeless history	19.5	20.6	16.7	25.0	20.3	22.2	0.0	18.8	20.0	15.3	23.1	7.7	17.6	37.1	33.3	12.0	31.0	32.5	7.5	14.4
Transitional housing history	27.2	27.1	27.8	25.0	28.4	20.6	5.9	31.3	60.0	19.4	26.9	7.7	23.5	48.6	26.7	27.7	31.0	40.0	25.0	18.9
Current work situation																				
Employed full-time	7.9	7.7	7.1	25.0	7.1	9.5	5.9	8.8	0.0	9.3	8.0	11.5	8.8	2.9	10.3	7.4	17.5	2.5	10.0	2.2
Employed part-time	12.0	10.7	15.7	0.0	8.6	12.7	0.0	15.0	40.0	14.4	8.0	15.4	20.6	5.7	10.3	12.3	7.0	15.0	22.5	9.0
Not working - looking for work	19.0	21.4	12.9	25.0	20.0	11.1	23.5	22.5	20.0	16.5	12.0	11.5	20.6	22.9	24.1	18.5	35.1	20.0	20.0	9.0
Not working - student/homemaker	12.8	4.8	32.9	0.0	12.9	7.9	0.0	18.8	20.0	4.1	0.0	3.8	2.9	2.9	17.2	25.9	12.3	17.5	10.0	12.4
Not working - not looking for work	38.8	43.5	27.1	50.0	44.3	42.9	58.8	27.5	20.0	43.3	64.0	38.5	35.3	51.4	31.0	30.9	24.6	40.0	30.0	51.7
Retired	9.5	11.9	4.3	0.0	7.1	15.9	11.8	7.5	0.0	12.4	8.0	19.2	11.8	14.3	6.9	4.9	3.5	5.0	7.5	15.7
Individual yearly income estimate																				
$8,600 or less	52.4	50.0	57.6	66.7	52.9	35.5	58.8	65.7	40.0	50.0	60.0	23.1	58.6	47.1	48.1	59.7	54.7	53.8	35.0	55.4
$8,601 - $11,600	28.4	32.1	21.2	0.0	33.8	37.1	17.6	17.9	40.0	27.2	36.0	34.6	24.1	41.2	37.0	20.8	15.1	33.3	35.0	32.5
$11,601 - $16,500	9.3	7.7	12.1	33.3	11.8	8.1	17.6	6.0	20.0	9.8	0.0	11.5	6.9	2.9	7.4	12.5	11.3	10.3	15.0	6.0
$16,501 - $23,200	2.7	2.6	3.0	0.0	0.0	4.8	0.0	3.0	0.0	4.3	0.0	11.5	3.4	0.0	0.0	2.8	5.7	0.0	2.5	2.4
$23,201 - $26,000	1.8	1.9	1.5	0.0	1.5	1.6	0.0	3.0	0.0	3.3	4.0	3.8	3.4	0.0	0.0	1.4	1.9	2.6	0.0	2.4
$26,001 - $35,000	2.2	3.2	0.0	0.0	0.0	6.5	0.0	1.5	0.0	3.3	0.0	11.5	0.0	2.9	0.0	1.4	5.7	0.0	2.5	1.2
Greater than $35,001	3.1	2.6	4.5	0.0	0.0	6.5	5.9	3.0	0.0	2.2	0.0	3.8	3.4	5.9	7.4	1.4	5.7	0.0	10.0	0.0

Attachment 6 2002 Survey Demographics																				
	Total	GENDER			ETHNICITY					RISKGRP							STAGE OF INFECTION			
	Sample	Male	Female	TG	Af Am	Anglo	API	Latino	Native Am	MSM Total	Af Am MSM	Anglo MSM	Latino MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
	246	**170**	**72**	**4**	**74**	**63**	**17**	**80**	**5**	**98**	**26**	**26**	**34**	**35**	**30**	**83**	**58**	**40**	**39**	**90**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Benefits Recevied																				
Food stamps	18.7	12.9	33.3	0.0	24.3	14.3	5.9	17.5	20.0	9.2	19.2	3.8	5.9	5.7	30.0	31.3	19.0	27.5	22.5	12.2
Long term disability	20.3	24.7	9.7	25.0	23.0	23.8	11.8	16.3	20.0	28.6	23.1	34.6	32.4	17.1	20.0	12.0	13.8	22.5	12.5	30.0
Short term disability	4.1	4.7	2.8	0.0	4.1	3.2	0.0	3.8	20.0	4.1	3.8	0.0	2.9	8.6	0.0	3.6	3.4	7.5	5.0	3.3
Supplemental Security Income (SSI)	39.4	41.8	33.3	50.0	51.4	36.5	52.9	26.3	40.0	34.7	42.3	30.8	32.4	54.3	46.7	36.1	20.7	40.0	37.5	53.3
Public Health Service, Bureau of Indian Affairs (BIA)	0.8	1.2	0.0	0.0	1.4	0.0	0.0	0.0	20.0	1.0	0.0	0.0	0.0	0.0	3.3	0.0	0.0	0.0	0.0	1.1
SDI	7.3	7.1	8.3	0.0	5.4	6.3	23.5	6.3	0.0	9.2	3.8	7.7	8.8	2.9	6.7	7.2	10.3	7.5	5.0	7.8
SSDI	22.0	26.5	12.5	0.0	13.5	31.7	17.6	20.0	40.0	33.7	11.5	50.0	38.2	20.0	16.7	10.8	8.6	27.5	20.0	30.0
VA Benefits	1.6	1.8	1.4	0.0	2.7	1.6	0.0	1.3	0.0	3.1	3.8	3.8	2.9	0.0	0.0	1.2	1.7	0.0	0.0	2.2
CHAMPUS	0.4	0.6	0.0	0.0	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	3.3	0.0	0.0	2.5	0.0	0.0
Annuity/Life insurance payments	0.4	0.6	0.0	0.0	0.0	1.6	0.0	0.0	0.0	1.0	0.0	3.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1
Retirement	4.9	5.9	1.4	25.0	1.4	12.7	5.9	2.5	0.0	9.2	0.0	23.1	5.9	5.7	0.0	1.2	6.9	2.5	7.5	4.4
Rent Supplement	11.4	11.8	11.1	0.0	13.5	15.9	11.8	6.3	20.0	14.3	11.5	23.1	11.8	5.7	13.3	9.6	10.3	7.5	12.5	13.3
Subsidized housing	33.3	31.2	37.5	50.0	32.4	34.9	41.2	31.3	40.0	36.7	30.8	38.5	44.1	31.4	26.7	32.5	20.7	37.5	27.5	43.3
General Assistance	9.3	11.2	5.6	0.0	9.5	14.3	0.0	7.5	0.0	8.2	11.5	7.7	8.8	14.3	20.0	4.8	12.1	12.5	7.5	6.7
Emergency Financial Assistance	2.4	2.4	2.8	0.0	1.4	4.8	0.0	2.5	0.0	3.1	0.0	7.7	2.9	2.9	0.0	2.4	1.7	0.0	5.0	3.3
WIC	5.7	2.4	13.9	0.0	1.4	3.2	0.0	12.5	0.0	2.0	0.0	0.0	5.9	2.9	6.7	10.8	8.6	2.5	10.0	3.3
TANF / CalWorks	7.7	1.2	23.6	0.0	12.2	4.8	0.0	8.8	0.0	1.0	0.0	0.0	2.9	2.9	6.7	18.1	8.6	15.0	7.5	4.4
% not eligible for benefits	14.6	17.3	6.8	50.0	6.7	29.3	25.0	7.3	0.0	15.3	5.6	37.5	10.5	33.3	10.0	6.8	15.4	16.0	28.6	6.7
Form of Health Insurance																				
Private insurance through work	6.9	7.1	5.6	25.0	2.7	11.1	11.8	7.5	0.0	10.2	7.7	15.4	8.8	5.7	6.7	3.6	12.1	2.5	12.5	4.4
COBRA or OBRA	1.2	0.6	2.8	0.0	1.4	1.6	5.9	0.0	0.0	1.0	3.8	0.0	0.0	0.0	3.3	1.2	0.0	2.5	2.5	1.1
Private insurance not through work	4.5	5.9	1.4	0.0	4.1	7.9	0.0	2.5	0.0	7.1	7.7	11.5	5.9	8.6	3.3	0.0	1.7	10.0	10.0	2.2
Medicare	25.6	31.2	13.9	0.0	24.3	27.0	35.3	23.8	20.0	34.7	30.8	38.5	32.4	20.0	30.0	15.7	20.7	25.0	20.0	30.0
Medi-Cal / Medicaid	52.0	49.4	55.6	100.0	55.4	50.8	58.8	47.5	60.0	49.0	38.5	46.2	58.8	62.9	40.0	55.4	29.3	60.0	40.0	68.9
% w/ health insurance	72.0	71.8	70.8	100.0	77.0	77.8	82.4	61.3	60.0	72.4	65.4	80.8	70.6	82.9	70.0	67.5	58.6	70.0	70.0	83.3
% w/o health insurance	28.0	28.2	29.2	0.0	23.0	22.2	17.6	38.8	40.0	27.6	34.6	19.2	29.4	17.1	30.0	32.5	41.4	30.0	30.0	16.7
Years w/ HIV																				
Less than 1 year	5.3	6.9	1.5	0.0	6.1	3.2	13.3	5.5	0.0	6.7	8.7	3.8	3.3	3.0	0.0	6.7	9.3	2.6	5.1	3.5
1 to 3 years	10.6	9.4	12.3	33.3	13.6	9.7	0.0	12.3	0.0	13.5	13.0	15.4	16.7	6.1	6.7	10.7	18.5	13.2	2.6	9.4
3 to 8 years	35.2	30.2	47.7	33.3	30.3	27.4	73.3	39.7	25.0	23.6	21.7	15.4	26.7	36.4	33.3	49.3	22.2	42.1	48.7	31.8
More than 8 years	48.9	53.5	38.5	33.3	50.0	59.7	13.3	42.5	75.0	56.2	56.5	65.4	53.3	54.5	60.0	33.3	50.0	42.1	43.6	55.3
Most likely way infected with HIV																				
Having sex with a man	65.2	58.6	80.3	75.0	72.2	63.5	64.7	63.8	20.0	85.6	80.0	96.2	91.2	54.3	16.7	63.4	59.6	67.5	67.5	68.9
Having sex with a woman	6.1	8.3	1.4	0.0	6.9	1.6	5.9	10.0	0.0	0.0	0.0	0.0	0.0	0.0	6.7	15.9	8.8	5.0	10.0	2.2
Having sex with a transgender	1.2	1.2	1.4	0.0	1.4	1.6	0.0	1.3	0.0	1.0	4.0	0.0	0.0	2.9	3.3	0.0	3.5	2.5	0.0	0.0
Sharing needles	13.5	17.8	2.8	25.0	6.9	27.0	5.9	8.8	40.0	0.0	0.0	0.0	0.0	37.1	66.7	0.0	15.8	10.0	15.0	14.4
Blood transfusions or products/Hemophilia	5.3	5.3	5.6	0.0	6.9	3.2	5.9	5.0	20.0	4.1	12.0	0.0	0.0	0.0	3.3	9.8	1.8	5.0	5.0	6.7
Acquired at birth	0.8	0.0	2.8	0.0	0.0	0.0	0.0	2.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.4	3.5	0.0	0.0	0.0
Other	0.4	0.6	0.0	0.0	0.0	0.0	0.0	1.3	0.0	1.0	0.0	0.0	2.9	0.0	0.0	0.0	0.0	2.5	0.0	0.0
Don't know	7.4	8.3	5.6	0.0	5.6	3.2	17.6	7.5	20.0	8.2	4.0	3.8	5.9	5.7	3.3	8.5	7.0	7.5	2.5	7.8
Received AIDS diagnosis	54.5	57.6	45.8	75.0	41.9	61.9	82.4	52.5	60.0	60.2	50.0	69.2	55.9	68.6	46.7	44.6	0.0	0.0	100.0	100.0
Years w/ AIDS																				
Less than 3 years	29.0	29.2	27.3	50.0	35.5	23.7	21.4	30.0	33.3	29.8	38.5	22.2	35.3	30.4	14.3	32.4	0.0	0.0	22.5	31.8
3 to 6 years	31.3	29.2	39.4	0.0	29.0	26.3	42.9	37.5	0.0	26.3	38.5	22.2	23.5	30.4	21.4	43.2	0.0	0.0	40.0	27.3
6 to 12 years	35.1	37.5	30.3	0.0	25.8	42.1	35.7	32.5	66.7	36.8	15.4	38.9	41.2	39.1	57.1	21.6	0.0	0.0	30.0	37.5
More than 12 years	4.6	4.2	3.0	50.0	9.7	7.9	0.0	0.0	0.0	7.0	7.7	16.7	0.0	0.0	7.1	2.7	0.0	0.0	7.5	3.4
Physical health is...																				
Poor	9.5	9.0	9.7	25.0	11.1	7.9	11.8	10.1	0.0	10.4	12.0	7.7	12.1	5.7	3.3	12.2	1.8	10.0	0.0	19.1
Fair	36.6	40.1	29.2	25.0	31.9	36.5	52.9	39.2	40.0	40.6	36.0	38.5	42.4	37.1	36.7	31.7	23.2	45.0	25.0	49.4
Good	38.7	37.7	41.7	25.0	43.1	41.3	23.5	32.9	60.0	38.5	48.0	38.5	33.3	40.0	43.3	36.6	50.0	40.0	45.0	27.0
Excellent	15.2	13.2	19.4	25.0	13.9	14.3	11.8	17.7	0.0	10.4	4.0	15.4	12.1	17.1	16.7	19.5	25.0	5.0	30.0	4.5

Attachment 6 2002 Survey Demographics																				
	Total	GENDER			ETHNICITY					RISKGRP							STAGE OF INFECTION			
	Sample	Male	Female	TG	Af Am	Anglo	API	Latino	Native Am	MSM Total	Af Am MSM	Anglo MSM	Latino MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
	246	**170**	**72**	**4**	**74**	**63**	**17**	**80**	**5**	**98**	**26**	**26**	**34**	**35**	**30**	**83**	**58**	**40**	**39**	**90**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Compare your physical health																				
Much worse	6.6	7.2	5.7	0.0	4.3	11.1	11.8	3.8	0.0	9.4	4.0	19.2	6.1	5.7	3.3	5.0	0.0	5.0	2.5	14.8
A little worse	13.3	15.6	8.6	0.0	12.9	17.5	5.9	12.7	0.0	14.6	16.0	15.4	18.2	20.0	10.0	10.0	8.9	27.5	10.0	13.6
About the same	19.5	19.8	18.6	25.0	22.9	19.0	17.6	16.5	40.0	20.8	24.0	11.5	18.2	20.0	20.0	17.5	33.9	15.0	20.0	13.6
A little better	21.2	22.2	18.6	25.0	20.0	15.9	17.6	26.6	40.0	21.9	24.0	15.4	27.3	22.9	23.3	18.8	16.1	20.0	15.0	23.9
Much better	39.4	35.3	48.6	50.0	40.0	36.5	47.1	40.5	20.0	33.3	32.0	38.5	30.3	31.4	43.3	48.8	41.1	32.5	52.5	34.1
Emotional health is...																				
Poor	9.9	10.8	6.9	25.0	13.9	7.9	11.8	7.6	0.0	11.5	16.0	11.5	9.1	8.6	6.7	9.8	7.1	10.0	5.0	14.6
Fair	35.4	33.5	38.9	50.0	36.1	28.6	41.2	40.5	40.0	35.4	36.0	23.1	42.4	28.6	43.3	35.4	23.2	37.5	30.0	44.9
Good	37.9	41.3	30.6	25.0	37.5	39.7	29.4	36.7	60.0	36.5	40.0	30.8	39.4	54.3	40.0	31.7	39.3	45.0	37.5	32.6
Excellent	16.9	14.4	23.6	0.0	12.5	23.8	17.6	15.2	0.0	16.7	8.0	34.6	9.1	8.6	10.0	23.2	30.4	7.5	27.5	7.9
Compare your emotional health																				
Much worse	5.0	6.1	2.9	0.0	5.7	3.2	5.9	6.6	0.0	5.3	12.0	0.0	6.5	5.7	3.3	5.1	0.0	5.0	5.1	6.9
A little worse	12.2	11.0	12.9	50.0	14.3	9.5	5.9	13.2	20.0	12.8	12.0	11.5	16.1	8.6	13.3	12.7	1.8	15.0	10.3	20.7
About the same	18.9	22.6	11.4	0.0	18.6	23.8	23.5	11.8	40.0	18.1	20.0	15.4	12.9	28.6	20.0	15.2	23.2	27.5	17.9	13.8
A little better	24.8	24.4	25.7	25.0	28.6	15.9	17.6	30.3	20.0	27.7	36.0	11.5	35.5	22.9	23.3	22.8	25.0	20.0	15.4	27.6
Much better	39.1	36.0	47.1	25.0	32.9	47.6	47.1	38.2	20.0	36.2	20.0	61.5	29.0	34.3	40.0	44.3	50.0	32.5	51.3	31.0
Never seen a doctor since seroconversion	0.8	1.2	0.0	0.0	2.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.3	1.2	3.4	0.0	0.0	0.0
12 mos or longer w/out med care	21.1	22.9	16.7	25.0	18.9	19.0	5.9	27.5	20.0	13.3	19.2	3.8	20.6	31.4	43.3	18.1	17.2	20.0	25.0	16.7
6 mos or longer w/out med care	25.6	29.4	16.7	25.0	23.0	34.9	5.9	21.3	40.0	20.4	23.1	15.4	26.5	48.6	56.7	10.8	19.0	30.0	22.5	25.6
After which, went back & see a doc?	84.9	83.6	88.2	100.0	83.3	87.5	100.0	80.0	100.0	90.0	80.0	100.0	90.0	77.8	87.5	84.2	81.8	85.7	100.0	84.0
Reason for returning to doctor																				
Returned b/c I got sicker	15.1	16.6	12.5	0.0	15.1	19.0	5.9	13.8	40.0	11.2	15.4	7.7	14.7	28.6	33.3	7.3	3.5	25.0	12.5	18.9
Returned b/c change in my income	2.8	3.5	1.4	0.0	2.7	6.3	0.0	0.0	20.0	1.0	3.8	0.0	0.0	8.6	10.0	0.0	0.0	5.0	0.0	3.3
Returned b/c change in insurance	4.5	4.7	4.2	0.0	2.7	4.8	0.0	6.3	20.0	3.1	3.8	0.0	5.9	5.7	6.7	4.8	0.0	7.5	2.5	2.2
Returned b/c heard about new dr.	4.5	4.7	4.2	0.0	6.8	7.9	0.0	0.0	20.0	2.0	3.8	3.8	0.0	8.6	16.7	1.2	3.4	2.5	7.5	2.2
Returned b/c change in attitudes	4.1	4.7	2.8	0.0	4.1	6.3	0.0	3.8	0.0	3.1	3.8	3.8	2.9	8.6	10.0	1.2	1.7	5.0	5.0	5.6
Returned b/c new meds	6.5	7.1	5.6	0.0	6.8	11.1	0.0	2.5	40.0	4.1	7.7	3.8	2.9	11.4	20.0	2.4	6.9	7.5	0.0	7.8
Returned b/c had stable housing	7.3	7.1	8.3	0.0	5.4	11.1	0.0	5.0	20.0	3.1	0.0	0.0	5.9	17.1	20.0	3.6	6.9	12.5	0.0	7.8
STD Diagnosis in last year																				
Hepatitis A or B	15.9	17.6	11.1	25.0	12.2	12.7	23.5	18.8	20.0	10.2	7.7	7.7	17.6	37.1	20.0	12.0	13.8	17.5	22.5	13.3
Hepatitis C	15.0	18.2	6.9	25.0	13.5	19.0	0.0	15.0	20.0	6.1	7.7	0.0	11.8	31.4	50.0	6.0	17.2	27.5	15.0	8.9
Syphilis	7.3	8.2	5.6	0.0	12.2	3.2	5.9	7.5	0.0	6.1	7.7	3.8	8.8	11.4	3.3	8.4	5.2	5.0	10.0	7.8
Herpes (genital)	8.9	10.6	5.6	0.0	5.4	9.5	11.8	10.0	20.0	9.2	0.0	11.5	11.8	17.1	6.7	6.0	5.2	2.5	7.5	13.3
Gonorrhea	2.4	2.9	1.4	0.0	4.1	3.2	0.0	1.3	0.0	0.0	0.0	0.0	0.0	8.6	0.0	3.6	1.7	5.0	2.5	2.2
Chlamydia	4.1	2.4	8.3	0.0	8.1	3.2	0.0	2.5	0.0	0.0	0.0	0.0	0.0	8.6	0.0	8.4	3.4	7.5	7.5	2.2
Genital warts	8.1	7.1	9.7	25.0	8.1	9.5	0.0	10.0	0.0	7.1	3.8	15.4	5.9	11.4	3.3	9.6	1.7	7.5	15.0	11.1
Yeast infections	12.2	5.3	29.2	0.0	14.9	12.9	17.6	10.0	0.0	4.1	0.0	12.0	2.9	11.4	10.0	22.9	6.9	15.0	12.5	13.5
Taking antiretrovirals / protease inhibitors	61.8	64.7	55.6	50.0	51.4	74.6	76.5	56.3	80.0	64.3	50.0	73.1	67.6	74.3	73.3	49.4	46.6	52.5	75.0	75.6
Taking antibiotics	30.9	31.8	26.4	75.0	24.3	38.1	35.3	27.5	40.0	34.7	19.2	46.2	38.2	40.0	30.0	22.9	8.6	22.5	27.5	50.0
Skipped medications...																				
Never/ Have not skipped	32.6	33.8	31.7	0.0	22.8	31.1	43.8	36.8	40.0	33.0	22.7	40.0	30.0	19.4	31.0	38.4	43.1	34.3	27.8	29.1
Once or twice a month	32.6	31.8	33.3	50.0	29.8	37.7	43.8	28.9	20.0	35.2	18.2	44.0	40.0	41.9	17.2	31.5	27.5	28.6	41.7	33.7
Once or twice a week	14.5	14.9	12.7	25.0	22.8	13.1	12.5	10.5	20.0	15.9	31.8	12.0	10.0	12.9	20.7	11.0	11.8	11.4	16.7	16.3
More than twice a week	6.8	8.4	3.2	0.0	10.5	3.3	0.0	7.9	0.0	10.2	13.6	4.0	13.3	3.2	6.9	4.1	5.9	5.7	2.8	9.3
I have stopped taking my medicine	13.6	11.0	19.0	25.0	14.0	14.8	0.0	15.8	20.0	5.7	13.6	0.0	6.7	22.6	24.1	15.1	11.8	20.0	11.1	11.6
Reasons for skipping medications																				
Side effects	21.5	17.6	30.6	25.0	24.3	19.0	23.5	23.8	0.0	21.4	26.9	15.4	23.5	14.3	30.0	21.7	10.3	25.0	20.0	28.9
Difficult schedule	17.1	17.1	16.7	25.0	23.0	17.5	5.9	13.8	0.0	15.3	23.1	11.5	14.7	20.0	26.7	14.5	19.0	7.5	20.0	21.1
Didn't want others to see the meds	10.6	7.6	15.3	50.0	14.9	4.8	5.9	11.3	0.0	7.1	11.5	3.8	5.9	8.6	16.7	13.3	8.6	10.0	5.0	14.4
Didn't understand directions	5.3	4.7	6.9	0.0	6.8	0.0	5.9	8.8	0.0	4.1	7.7	0.0	5.9	2.9	3.3	8.4	5.2	2.5	5.0	4.4
Feel that medications didnt work	4.9	2.9	8.3	25.0	6.8	4.8	0.0	5.0	0.0	2.0	7.7	0.0	0.0	5.7	6.7	7.2	5.2	5.0	5.0	4.4

Attachment 6 2002 Survey Demographics																				
	Total	GENDER			ETHNICITY					RISKGRP							STAGE OF INFECTION			
	Sample	Male	Female	TG	Af Am	Anglo	API	Latino	Native Am	MSM Total	Af Am MSM	Anglo MSM	Latino MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
	246	**170**	**72**	**4**	**74**	**63**	**17**	**80**	**5**	**98**	**26**	**26**	**34**	**35**	**30**	**83**	**58**	**40**	**39**	**90**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Reasons for skipping medications (cont…)																				
Affordability	3.3	2.4	5.6	0.0	4.1	1.6	5.9	3.8	0.0	3.1	0.0	0.0	5.9	0.0	0.0	6.0	6.9	5.0	2.5	0.0
Forgot	38.2	39.4	34.7	50.0	33.8	42.9	41.2	36.3	60.0	38.8	30.8	38.5	41.2	40.0	50.0	32.5	32.8	35.0	40.0	41.1
Ran out	9.3	10.0	8.3	0.0	14.9	6.3	11.8	5.0	20.0	11.2	26.9	7.7	2.9	8.6	13.3	6.0	6.9	7.5	5.0	12.2
Hard to coordinate with food	15.1	15.9	11.3	50.0	14.9	15.9	5.9	19.0	0.0	16.3	26.9	7.7	20.6	20.0	23.3	8.5	13.8	7.7	17.5	17.8
Didn't want to take them	20.7	20.6	18.1	75.0	18.9	27.0	5.9	21.3	0.0	19.4	15.4	19.2	23.5	28.6	30.0	15.7	22.4	12.5	15.0	26.7
Homeless	7.7	8.2	6.9	0.0	8.1	12.7	0.0	5.0	0.0	5.1	11.5	0.0	2.9	14.3	20.0	3.6	10.3	12.5	2.5	7.8
Felt didn't need meds anymore	4.9	4.1	6.9	0.0	5.4	1.6	0.0	8.8	0.0	3.1	0.0	3.8	5.9	2.9	3.3	8.4	1.7	5.0	5.0	4.4
Doctor advised me to stop	8.5	5.9	15.3	0.0	6.8	9.5	11.8	10.0	0.0	7.1	11.5	3.8	8.8	5.7	13.3	9.6	8.6	12.5	0.0	10.0
Received mental health service	56.5	59.4	48.6	75.0	56.8	69.8	47.1	45.0	60.0	61.2	53.8	69.2	61.8	80.0	53.3	42.2	51.7	57.5	52.5	63.3
Inpatient (in a hospital at least overnight)	13.0	12.9	12.5	25.0	12.2	15.9	5.9	11.3	20.0	7.1	3.8	3.8	11.8	37.1	13.3	9.6	12.1	7.5	17.5	12.2
Individual counseling/therapy	50.4	52.4	45.8	50.0	48.6	63.5	41.2	41.3	60.0	50.0	46.2	53.8	47.1	74.3	56.7	38.6	43.1	47.5	60.0	55.6
Group counseling/therapy	37.4	41.2	30.6	0.0	36.5	54.0	23.5	27.5	20.0	37.8	38.5	42.3	32.4	57.1	36.7	28.9	37.9	37.5	30.0	42.2
Taken mental related medicines	28.5	34.1	13.9	50.0	23.0	46.0	17.6	21.3	20.0	35.7	26.9	50.0	38.2	51.4	30.0	9.6	15.5	40.0	22.5	33.3
In the last two years, received …																				
Anxiety diagnosis	34.1	36.5	27.8	50.0	33.8	46.0	35.3	27.5	0.0	35.7	30.8	46.2	38.2	54.3	30.0	25.3	22.4	42.5	27.5	40.0
Bipolar disorder	7.3	9.4	2.8	0.0	10.8	7.9	0.0	3.8	0.0	7.1	15.4	3.8	2.9	11.4	13.3	3.6	10.3	5.0	5.0	6.7
Dementia depression	2.8	3.5	1.4	0.0	1.4	0.0	0.0	6.3	0.0	5.1	0.0	0.0	11.8	0.0	0.0	2.4	0.0	2.5	2.5	3.3
Depression diagnosis	50.4	54.7	40.3	50.0	56.8	52.4	41.2	42.5	40.0	57.1	65.4	53.8	55.9	65.7	46.7	37.3	39.7	62.5	50.0	54.4
Alcohol																				
Not used in yr	56.1	52.4	65.3	50.0	59.5	41.3	82.4	62.5	40.0	53.1	53.8	26.9	67.6	48.6	46.7	66.3	46.6	60.0	47.5	65.6
Not used in last six months	6.5	5.9	8.3	0.0	2.7	1.6	0.0	13.8	40.0	4.1	3.8	0.0	8.8	2.9	13.3	8.4	6.9	7.5	12.5	2.2
Used in last 6 months	10.2	9.4	12.5	0.0	10.8	14.3	11.8	5.0	0.0	7.1	7.7	11.5	0.0	11.4	13.3	12.0	10.3	7.5	17.5	6.7
Used less than once a month	8.9	10.0	6.9	0.0	5.4	14.3	5.9	8.8	0.0	12.2	7.7	23.1	8.8	8.6	6.7	6.0	8.6	12.5	7.5	7.8
Used at least once a month	9.8	12.4	4.2	0.0	6.8	22.2	0.0	5.0	20.0	14.3	7.7	34.6	5.9	14.3	6.7	3.6	12.1	5.0	10.0	12.2
Used once a week or more	8.5	10.0	2.8	50.0	14.9	6.3	0.0	5.0	0.0	9.2	19.2	3.8	8.8	14.3	13.3	3.6	15.5	7.5	5.0	5.6
Marijuana																				
Not used in yr	68.7	62.4	81.9	100.0	74.3	57.1	82.4	77.5	0.0	70.4	80.8	65.4	70.6	40.0	63.3	80.7	62.1	77.5	75.0	68.9
Not used in last six months	4.1	4.7	2.8	0.0	1.4	0.0	0.0	7.5	40.0	4.1	3.8	0.0	8.8	2.9	10.0	2.4	3.4	5.0	5.0	2.2
Used in last 6 months	8.5	11.2	2.8	0.0	4.1	14.3	5.9	6.3	40.0	9.2	3.8	7.7	8.8	22.9	6.7	2.4	5.2	2.5	2.5	13.3
Used less than once a month	2.4	2.4	2.8	0.0	1.4	4.8	0.0	2.5	0.0	0.0	0.0	0.0	0.0	5.7	3.3	3.6	1.7	0.0	5.0	2.2
Used at least once a month	5.3	6.5	2.8	0.0	4.1	7.9	11.8	2.5	20.0	7.1	3.8	11.5	2.9	2.9	6.7	3.6	10.3	5.0	2.5	3.3
Used once a week or more	11.0	12.9	6.9	0.0	14.9	15.9	0.0	3.8	0.0	9.2	7.7	15.4	8.8	25.7	10.0	7.2	17.2	10.0	10.0	10.0
Crack																				
Not used in yr	84.1	80.6	91.7	100.0	82.4	82.5	100.0	86.3	80.0	84.7	80.8	92.3	79.4	68.6	80.0	91.6	75.9	80.0	92.5	91.1
Not used in last six months	4.5	5.3	2.8	0.0	4.1	1.6	0.0	7.5	20.0	5.1	3.8	0.0	11.8	5.7	6.7	2.4	6.9	7.5	2.5	1.1
Used in last 6 months	4.1	4.7	2.8	0.0	5.4	4.8	0.0	2.5	0.0	6.1	7.7	3.8	5.9	2.9	6.7	1.2	3.4	2.5	2.5	4.4
Used less than once a month	1.6	1.8	1.4	0.0	0.0	3.2	0.0	2.5	0.0	0.0	0.0	0.0	0.0	5.7	0.0	2.4	1.7	2.5	0.0	1.1
Used at least once a month	2.0	2.9	0.0	0.0	1.4	4.8	0.0	1.3	0.0	2.0	0.0	3.8	2.9	5.7	3.3	0.0	1.7	5.0	0.0	1.1
Used once a week or more	3.7	4.7	1.4	0.0	6.8	3.2	0.0	0.0	0.0	2.0	7.7	0.0	0.0	11.4	3.3	2.4	10.3	2.5	2.5	1.1
Heroin																				
Not used in yr	90.7	88.2	95.8	100.0	95.9	87.3	100.0	90.0	60.0	92.9	96.2	92.3	88.2	74.3	83.3	97.6	94.8	82.5	87.5	96.7
Not used in last six months	4.1	5.3	1.4	0.0	2.7	1.6	0.0	6.3	20.0	4.1	3.8	0.0	8.8	8.6	6.7	1.2	3.4	7.5	5.0	2.2
Used in last 6 months	2.8	4.1	0.0	0.0	1.4	4.8	0.0	1.3	20.0	2.0	0.0	3.8	2.9	11.4	3.3	0.0	0.0	0.0	7.5	1.1
Used less than once a month	0.8	0.6	1.4	0.0	0.0	1.6	0.0	1.3	0.0	0.0	0.0	0.0	0.0	2.9	0.0	1.2	0.0	2.5	0.0	0.0
Used at least once a month	0.8	1.2	0.0	0.0	0.0	3.2	0.0	0.0	0.0	1.0	0.0	3.8	0.0	2.9	0.0	0.0	0.0	5.0	0.0	0.0
Used once a week or more	0.8	0.6	1.4	0.0	0.0	1.6	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	6.7	0.0	1.7	2.5	0.0	0.0

Attachment 6 2002 Survey Demographics																				
	Total	GENDER			ETHNICITY					RISKGRP							STAGE OF INFECTION			
	Sample	Male	Female	TG	Af Am	Anglo	API	Latino	Native Am	MSM Total	Af Am MSM	Anglo MSM	Latino MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
	246	**170**	**72**	**4**	**74**	**63**	**17**	**80**	**5**	**98**	**26**	**26**	**34**	**35**	**30**	**83**	**58**	**40**	**39**	**90**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Crystal Meth																				
Not used in yr	82.5	78.2	93.1	75.0	93.2	68.3	100.0	82.5	40.0	84.7	92.3	80.8	76.5	51.4	70.0	97.6	87.9	70.0	85.0	85.6
Not used in last six months	3.7	4.7	1.4	0.0	2.7	0.0	0.0	6.3	40.0	4.1	3.8	0.0	8.8	2.9	10.0	1.2	3.4	7.5	2.5	2.2
Used in last 6 months	5.3	6.5	2.8	0.0	2.7	12.7	0.0	2.5	20.0	2.0	0.0	3.8	2.9	22.9	10.0	0.0	0.0	5.0	5.0	6.7
Used less than once a month	2.0	2.4	1.4	0.0	1.4	3.2	0.0	1.3	0.0	2.0	3.8	3.8	0.0	5.7	0.0	1.2	3.4	2.5	2.5	0.0
Used at least once a month	3.3	4.1	0.0	25.0	0.0	6.3	0.0	5.0	0.0	6.1	0.0	7.7	11.8	5.7	0.0	0.0	3.4	5.0	2.5	3.3
Used once a week or more	3.3	4.1	1.4	0.0	0.0	9.5	0.0	2.5	0.0	1.0	0.0	3.8	0.0	11.4	10.0	0.0	1.7	10.0	2.5	2.2
Speed																				
Not used in yr	92.7	91.2	95.8	100.0	95.9	92.1	100.0	91.3	80.0	93.9	96.2	92.3	91.2	80.0	90.0	97.6	96.6	87.5	90.0	96.7
Not used in last six months	4.5	5.3	2.8	0.0	2.7	4.8	0.0	6.3	0.0	4.1	3.8	0.0	8.8	11.4	6.7	1.2	3.4	12.5	5.0	1.1
Used in last 6 months	1.6	2.4	0.0	0.0	1.4	1.6	0.0	0.0	20.0	1.0	0.0	3.8	0.0	5.7	3.3	0.0	0.0	0.0	2.5	1.1
Used less than once a month	0.4	0.0	1.4	0.0	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.2	0.0	0.0	0.0	0.0
Used at least once a month	0.4	0.6	0.0	0.0	0.0	1.6	0.0	0.0	0.0	1.0	0.0	3.8	0.0	0.0	0.0	0.0	0.0	0.0	2.5	0.0
Used once a week or more	0.4	0.6	0.0	0.0	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	2.9	0.0	0.0	0.0	0.0	0.0	1.1
GHB																				
Not used in yr	93.5	92.4	95.8	100.0	95.9	92.1	100.0	92.5	100.0	94.9	96.2	96.2	91.2	82.9	90.0	97.6	94.8	90.0	92.5	96.7
Not used in last six months	4.1	4.7	2.8	0.0	2.7	3.2	0.0	6.3	0.0	4.1	3.8	0.0	8.8	8.6	6.7	1.2	3.4	10.0	5.0	1.1
Used in last 6 months	1.2	1.8	0.0	0.0	1.4	3.2	0.0	0.0	0.0	1.0	0.0	3.8	0.0	2.9	3.3	0.0	0.0	0.0	2.5	1.1
Used less than once a month	0.8	0.6	1.4	0.0	0.0	1.6	0.0	1.3	0.0	0.0	0.0	0.0	0.0	2.9	0.0	1.2	1.7	0.0	0.0	0.0
Used once a week or more	0.4	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.9	0.0	0.0	0.0	0.0	0.0	1.1
Poppers																				
Not used in yr	87.0	82.9	95.8	100.0	93.2	76.2	94.1	90.0	60.0	86.7	88.5	80.8	88.2	62.9	86.7	97.6	86.2	80.0	82.5	94.4
Not used in last six months	4.1	4.7	2.8	0.0	1.4	3.2	0.0	6.3	20.0	3.1	0.0	0.0	8.8	8.6	10.0	1.2	5.2	10.0	5.0	1.1
Used in last 6 months	3.3	4.7	0.0	0.0	2.7	3.2	5.9	2.5	20.0	3.1	3.8	0.0	2.9	11.4	3.3	0.0	5.2	0.0	2.5	2.2
Used less than once a month	3.7	4.7	1.4	0.0	1.4	11.1	0.0	1.3	0.0	4.1	3.8	11.5	0.0	11.4	0.0	1.2	1.7	5.0	7.5	1.1
Used at least once a month	1.2	1.8	0.0	0.0	1.4	3.2	0.0	0.0	0.0	2.0	3.8	3.8	0.0	2.9	0.0	0.0	0.0	5.0	0.0	1.1
Used once a week or more	0.8	1.2	0.0	0.0	0.0	3.2	0.0	0.0	0.0	1.0	0.0	3.8	0.0	2.9	0.0	0.0	1.7	0.0	2.5	0.0
Ecstasy																				
Not used in yr	91.5	89.4	95.8	100.0	94.6	85.7	100.0	92.5	100.0	91.8	92.3	88.5	91.2	77.1	90.0	97.6	94.8	82.5	87.5	96.7
Not used in last six months	4.5	5.3	2.8	0.0	2.7	4.8	0.0	6.3	0.0	4.1	3.8	0.0	8.8	11.4	6.7	1.2	3.4	12.5	5.0	1.1
Used in last 6 months	1.2	1.8	0.0	0.0	2.7	1.6	0.0	0.0	0.0	2.0	3.8	3.8	0.0	0.0	3.3	0.0	0.0	0.0	2.5	1.1
Used less than once a month	1.6	1.8	1.4	0.0	0.0	4.8	0.0	1.3	0.0	1.0	0.0	3.8	0.0	5.7	0.0	1.2	0.0	5.0	2.5	0.0
Used at least once a month	0.4	0.6	0.0	0.0	0.0	1.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.9	0.0	0.0	1.7	0.0	0.0	0.0
Used once a week or more	0.8	1.2	0.0	0.0	0.0	1.6	0.0	0.0	0.0	1.0	0.0	3.8	0.0	2.9	0.0	0.0	0.0	0.0	2.5	1.1
Pills not prescribed by Dr.																				
Not used in yr	91.1	88.8	95.8	100.0	94.6	90.5	100.0	88.8	60.0	91.8	92.3	100.0	85.3	80.0	83.3	97.6	91.4	82.5	95.0	93.3
Not used in last six months	4.9	6.5	1.4	0.0	2.7	4.8	0.0	6.3	20.0	4.1	3.8	0.0	8.8	14.3	6.7	1.2	3.4	12.5	5.0	2.2
Used in last 6 months	2.0	2.9	0.0	0.0	2.7	0.0	0.0	2.5	20.0	4.1	3.8	0.0	5.9	0.0	3.3	0.0	0.0	0.0	0.0	4.4
Used at least once a month	1.6	1.2	2.8	0.0	0.0	3.2	0.0	2.5	0.0	0.0	0.0	0.0	0.0	2.9	6.7	1.2	5.2	2.5	0.0	0.0
Used once a week or more	0.4	0.6	0.0	0.0	0.0	1.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.9	0.0	0.0	0.0	2.5	0.0	0.0
Injected substance history	22.8	27.6	11.1	25.0	16.2	46.0	11.8	7.5	60.0	0.0	0.0	0.0	0.0	91.4	80.0	0.0	22.4	25.0	30.0	20.0
Country of origin																				
The United States	68.3	69.2	67.2	50.0	94.3	98.3	7.1	34.7	80.0	57.6	83.3	95.8	28.1	96.9	88.0	60.6	73.5	80.0	75.0	58.7
Mexico	12.5	9.6	19.0	25.0	1.9	0.0	0.0	34.7	0.0	14.1	5.6	0.0	34.4	0.0	8.0	18.2	12.2	5.7	11.1	13.3
Puerto Rico or other US Territories	1.4	2.1	0.0	0.0	0.0	0.0	0.0	4.2	0.0	3.5	0.0	0.0	9.4	0.0	0.0	0.0	0.0	2.9	0.0	2.7
Central America	7.2	5.5	10.3	25.0	0.0	0.0	0.0	20.8	0.0	7.1	0.0	0.0	18.8	0.0	4.0	12.1	6.1	5.7	8.3	8.0
Other	10.6	13.7	3.4	0.0	3.8	1.7	92.9	5.6	20.0	17.6	11.1	4.2	9.4	3.1	0.0	9.1	8.2	5.7	5.6	17.3
Citizenship status																				
Citizen	24.4	26.5	19.4	25.0	24.3	14.3	64.7	23.8	40.0	32.7	26.9	19.2	35.3	17.1	16.7	20.5	22.4	22.5	10.0	34.4
Have a visa (student, temp, or pemanent)	2.8	4.1	0.0	0.0	1.4	1.6	5.9	5.0	0.0	7.1	3.8	3.8	11.8	0.0	0.0	0.0	1.7	0.0	0.0	4.4
Have legal refugee or on asylum status	1.2	0.6	2.8	0.0	0.0	0.0	0.0	3.8	0.0	0.0	0.0	0.0	0.0	0.0	3.3	2.4	1.7	0.0	2.5	1.1
Undocumented	7.3	5.3	9.7	50.0	0.0	0.0	5.9	21.3	0.0	5.1	0.0	0.0	14.7	0.0	3.3	14.5	6.9	7.5	12.5	4.4
Other	1.2	1.8	0.0	0.0	0.0	0.0	11.8	1.3	0.0	2.0	0.0	0.0	2.9	0.0	0.0	1.2	1.7	0.0	0.0	1.1

Attachment 6 2002 Survey Demographics																	
	Total	Location								SPECIAL POPULATIONS							
	Sample	SPA1	SPA2	SPA3	SPA4	SPA5	SPA6	SPA7	SPA8	UNDOC	NON-IDU2	WCB (13-45yo)	REC INC	Severe MH	Current Hmls/ Trans	Hx of Hmls	Hx of Trans
	246	**9**	**22**	**21**	**78**	**17**	**51**	**17**	**31**	**18**	**51**	**53**	**41**	**81**	**38**	**48**	**67**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Serostatus																	
HIV+ with disabling symptoms	57.0	87.5	72.7	63.2	56.9	37.5	42.2	56.3	66.7	43.8	50.0	50.0	57.5	68.5	54.3	55.3	54.1
HIV+ with no symptoms	43.0	12.5	27.3	36.8	43.1	62.5	57.8	43.8	33.3	56.3	50.0	50.0	42.5	31.5	45.7	44.7	45.9
AGE (mean value)	42.7	51.1	42.5	43.2	43.6	46.7	39.4	41.0	42.6	35.0	41.5	35.0	40.8	43.6	40.8	40.2	40.4
AGEGROUP																	
13-19	1.3	0.0	0.0	0.0	1.4	0.0	4.1	0.0	0.0	5.6	2.1	3.8	0.0	0.0	0.0	0.0	0.0
20-24	1.7	0.0	4.5	4.8	0.0	0.0	4.1	0.0	0.0	0.0	2.1	5.7	2.4	1.3	5.3	2.1	1.5
25-54	87.2	62.5	77.3	95.2	89.0	76.5	85.7	100.0	93.1	94.4	89.4	90.6	95.1	90.9	89.5	95.8	95.5
55+	9.8	37.5	18.2	0.0	9.6	23.5	6.1	0.0	6.9	0.0	6.4	0.0	2.4	7.8	5.3	2.1	3.0
Gender																	
Male	69.1	88.9	86.4	66.7	74.4	82.4	43.1	82.4	67.7	50.0	76.5	0.0	85.4	76.5	78.9	72.9	68.7
Female	29.3	11.1	13.6	33.3	21.8	17.6	56.9	17.6	29.0	38.9	19.6	100.0	12.2	21.0	21.1	25.0	29.9
Transgender - MTF	1.2	0.0	0.0	0.0	2.6	0.0	0.0	0.0	3.2	11.1	3.9	0.0	2.4	1.2	0.0	2.1	1.5
Transgender - FTM	0.4	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.2	0.0	0.0	0.0
Ethnicity																	
African American (Black)	30.2	55.6	14.3	14.3	16.7	23.5	60.8	17.6	38.7	0.0	41.2	41.5	31.7	27.5	42.1	31.3	31.8
Latino / Hispanic	32.7	22.2	28.6	47.6	33.3	11.8	29.4	82.4	16.1	94.4	29.4	41.5	24.4	27.5	18.4	31.3	37.9
Asian / Pacific Islander (API)	6.9	0.0	4.8	14.3	7.7	0.0	2.0	0.0	19.4	5.6	5.9	5.7	0.0	5.0	2.6	0.0	1.5
Native American	2.0	0.0	9.5	0.0	1.3	5.9	2.0	0.0	0.0	0.0	3.9	0.0	4.9	1.3	0.0	2.1	4.5
White / Caucasian (non Hispanic)	25.7	11.1	42.9	23.8	41.0	47.1	2.0	0.0	22.6	0.0	17.6	9.4	31.7	35.0	34.2	29.2	19.7
Mixed Race	1.6	0.0	0.0	0.0	0.0	11.8	2.0	0.0	3.2	0.0	0.0	1.9	4.9	2.5	0.0	4.2	3.0
Other	0.8	11.1	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	2.0	0.0	2.4	1.3	2.6	2.1	1.5
Sexual orientation																	
Heterosexual/Straight	42.4	44.4	31.8	65.0	31.2	29.4	64.7	47.1	30.0	77.8	27.5	84.9	31.7	26.6	29.7	39.6	40.3
Homosexual - Gay male	40.7	33.3	50.0	25.0	48.1	52.9	27.5	41.2	43.3	22.2	39.2	0.0	41.5	59.5	40.5	39.6	37.3
Homosexual - Lesbian	2.1	0.0	0.0	5.0	0.0	5.9	2.0	0.0	6.7	0.0	0.0	9.4	2.4	2.5	0.0	2.1	3.0
Bisexual	13.6	11.1	18.2	5.0	19.5	11.8	3.9	11.8	20.0	0.0	29.4	3.8	19.5	11.4	24.3	14.6	14.9
Other	1.2	11.1	0.0	0.0	1.3	0.0	2.0	0.0	0.0	0.0	3.9	1.9	4.9	0.0	5.4	4.2	4.5
Highest level of education																	
Grade school or less	9.4	11.1	0.0	14.3	10.3	0.0	13.7	17.6	3.3	33.3	7.8	11.3	7.3	8.8	7.9	8.3	9.0
Some high school	19.2	11.1	22.7	33.3	16.7	11.8	21.6	35.3	6.7	22.2	7.8	32.1	12.2	16.3	18.4	16.7	22.4
Graduated High School/GED/trade school	29.8	33.3	36.4	28.6	28.2	17.6	33.3	23.5	33.3	22.2	29.4	28.3	39.0	27.5	42.1	35.4	29.9
Some College / 2 year college degree	29.0	33.3	18.2	23.8	25.6	52.9	27.5	23.5	40.0	11.1	45.1	20.8	31.7	31.3	23.7	31.3	26.9
Completed 4 year College	6.1	11.1	4.5	0.0	6.4	17.6	3.9	0.0	10.0	5.6	5.9	3.8	4.9	7.5	2.6	4.2	7.5
Graduate Level	6.5	0.0	18.2	0.0	12.8	0.0	0.0	0.0	6.7	5.6	3.9	3.8	4.9	8.8	5.3	4.2	4.5
Where do you currently live?																	
In my own apartment/house I own	8.5	22.2	22.7	5.0	12.0	5.9	2.1	0.0	3.6	0.0	4.1	4.1	7.5	8.9	0.0	4.2	3.1
In my own apartment/house I rent	63.6	55.6	31.8	50.0	70.7	76.5	68.8	88.2	50.0	75.0	59.2	71.4	45.0	62.0	0.0	39.6	50.8
At my parent's/relative's apt./house	7.6	0.0	9.1	25.0	0.0	0.0	14.6	11.8	7.1	6.3	10.2	8.2	5.0	5.1	0.0	2.1	6.2
Crashing w/ someone w/out paying rent	3.4	0.0	0.0	0.0	5.3	0.0	4.2	0.0	7.1	0.0	6.1	0.0	2.5	2.5	21.1	4.2	3.1
SRO	3.0	0.0	4.5	10.0	1.3	0.0	4.2	0.0	3.6	0.0	4.1	6.1	7.5	2.5	18.4	8.3	6.2
In a "supportive living" facility	2.5	0.0	9.1	0.0	2.7	0.0	0.0	0.0	7.1	0.0	2.0	0.0	7.5	5.1	0.0	8.3	3.1
Group home/residence (e.g residential drug tx)	4.2	11.1	13.6	5.0	2.7	0.0	0.0	0.0	10.7	0.0	6.1	4.1	12.5	6.3	26.3	14.6	15.4
In a half-way house or transitional housing	3.0	11.1	9.1	5.0	1.3	5.9	0.0	0.0	3.6	0.0	4.1	2.0	10.0	3.8	18.4	6.3	7.7
Skilled nursing home	0.8	0.0	0.0	0.0	0.0	0.0	2.1	0.0	3.6	6.3	0.0	0.0	0.0	0.0	0.0	2.1	1.5
Homeless (on the street/in car)	1.3	0.0	0.0	0.0	2.7	5.9	0.0	0.0	0.0	6.3	2.0	0.0	0.0	2.5	7.9	4.2	3.1
Homeless shelter	1.3	0.0	0.0	0.0	1.3	5.9	2.1	0.0	0.0	0.0	0.0	2.0	0.0	0.0	7.9	4.2	0.0
Jail or correctional facility	0.4	0.0	0.0	0.0	0.0	0.0	2.1	0.0	0.0	6.3	0.0	2.0	2.5	1.3	0.0	2.1	0.0
Other	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.6	0.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0
Living situation safe	91.6	87.5	90.5	84.6	93.8	94.1	84.6	92.9	100.0	80.0	88.1	90.2	86.5	95.9	93.8	83.7	87.8
Living situation habitable	92.4	100.0	95.0	93.3	90.6	88.2	91.2	87.5	100.0	60.0	92.5	87.5	87.2	94.4	90.3	84.8	88.7
Living situation stable	86.5	71.4	89.5	90.9	87.3	76.5	81.8	100.0	90.9	54.5	86.1	82.9	74.3	88.1	62.1	65.9	76.5
Live alone	47.4	75.0	35.0	31.3	51.4	53.3	44.7	53.3	44.0	25.0	50.0	15.0	47.1	55.6	29.0	37.5	38.2

Attachment 6 2002 Survey Demographics																	
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	Sample	SPA1	SPA2	SPA3	SPA4	SPA5	SPA6	SPA7	SPA8	UNDOC	NON-IDU2	WCB (13-45yo)	REC INC	Severe MH	Current Hmls/ Trans	Hx of Hmls	Hx of Trans
	246	**9**	**22**	**21**	**78**	**17**	**51**	**17**	**31**	**18**	**51**	**53**	**41**	**81**	**38**	**48**	**67**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
# of other adults living at home																	
One other adult	49.1	0.0	40.0	53.8	54.5	62.5	50.0	42.9	43.8	55.6	36.4	58.8	28.6	51.4	29.6	46.4	38.9
2-3 other adults	31.6	0.0	26.7	23.1	33.3	25.0	40.0	28.6	37.5	33.3	40.9	29.4	33.3	28.6	22.2	17.9	27.8
4+ other adults	19.3	100.0	33.3	23.1	12.1	12.5	10.0	28.6	18.8	11.1	22.7	11.8	38.1	20.0	48.1	35.7	33.3
# of children living at home	9.9																
One child at home	39.4	100.0	71.4	42.9	27.8	50.0	37.5	50.0	25.0	66.7	27.3	44.4	45.5	47.1	33.3	33.3	27.3
2-3 children	50.7	0.0	28.6	57.1	66.7	50.0	37.5	50.0	75.0	22.2	36.4	38.9	54.5	52.9	58.3	61.1	63.6
4+ children	9.9	0.0	0.0	0.0	5.6	0.0	25.0	0.0	0.0	11.1	36.4	16.7	0.0	0.0	8.3	5.6	9.1
Time in half-way/transitional housing																	
Never	82.1	66.7	72.7	85.7	82.1	70.6	88.2	94.1	80.6	61.1	80.4	79.2	70.7	82.7	57.9	66.7	34.3
Less than a month	2.4	0.0	0.0	0.0	3.8	5.9	0.0	0.0	6.5	0.0	2.0	1.9	4.9	4.9	7.9	4.2	9.0
1-3 months	4.9	22.2	13.6	4.8	3.8	11.8	0.0	0.0	3.2	11.1	5.9	1.9	17.1	6.2	18.4	18.8	17.9
4 months to 1 yr.	6.1	11.1	4.5	4.8	7.7	11.8	3.9	5.9	3.2	5.6	7.8	9.4	4.9	3.7	7.9	6.3	22.4
More than 1 yr.	4.5	0.0	9.1	4.8	2.6	0.0	7.8	0.0	6.5	22.2	3.9	7.5	2.4	2.5	7.9	4.2	16.4
Time homeless (on the street/in car)?																	
Never	86.2	88.9	72.7	90.5	89.7	64.7	92.2	88.2	83.9	94.4	86.3	92.5	48.8	81.5	63.2	29.2	70.1
Less than a month	4.1	0.0	9.1	0.0	1.3	23.5	2.0	0.0	6.5	5.6	3.9	1.9	14.6	6.2	10.5	20.8	11.9
1-3 months	4.1	0.0	9.1	4.8	2.6	11.8	3.9	5.9	0.0	0.0	5.9	5.7	12.2	6.2	2.6	20.8	6.0
4 months to 1 yr.	3.3	11.1	9.1	0.0	3.8	0.0	0.0	0.0	6.5	0.0	2.0	0.0	12.2	4.9	15.8	16.7	9.0
More than 1 yr.	2.4	0.0	0.0	4.8	2.6	0.0	2.0	5.9	3.2	0.0	2.0	0.0	12.2	1.2	7.9	12.5	3.0
Time in a homeless shelter																	
Never	88.6	88.9	90.9	85.7	91.0	88.2	86.3	100.0	80.6	77.8	90.2	84.9	63.4	86.4	71.1	41.7	71.6
Less than a month	5.7	11.1	9.1	4.8	5.1	0.0	2.0	0.0	16.1	0.0	5.9	1.9	24.4	8.6	15.8	29.2	14.9
1-3 months	2.4	0.0	0.0	0.0	3.8	11.8	2.0	0.0	0.0	5.6	2.0	1.9	4.9	3.7	7.9	12.5	4.5
4 months to 1 yr.	1.6	0.0	0.0	4.8	0.0	0.0	5.9	0.0	0.0	11.1	0.0	5.7	4.9	1.2	2.6	8.3	3.0
More than 1 yr.	1.6	0.0	0.0	4.8	0.0	0.0	3.9	0.0	3.2	5.6	2.0	5.7	2.4	0.0	2.6	8.3	6.0
Time in a jail or correctional facility																	
Never	83.7	66.7	59.1	81.0	91.0	82.4	92.2	82.4	77.4	94.4	76.5	92.5	2.4	81.5	65.8	47.9	70.1
Less than a month	2.4	0.0	4.5	0.0	3.8	0.0	0.0	5.9	3.2	5.6	5.9	0.0	14.6	2.5	2.6	8.3	6.0
1-3 months	3.7	0.0	18.2	0.0	0.0	5.9	2.0	0.0	9.7	0.0	3.9	1.9	22.0	7.4	10.5	16.7	7.5
4 months to 1 yr.	5.7	22.2	13.6	4.8	5.1	0.0	2.0	0.0	9.7	0.0	7.8	3.8	34.1	6.2	15.8	12.5	10.4
More than 1 yr.	4.5	11.1	4.5	14.3	0.0	11.8	3.9	11.8	0.0	0.0	5.9	1.9	26.8	2.5	5.3	14.6	6.0
Homeless history	19.5	11.1	27.3	19.0	14.1	41.2	17.6	11.8	25.8	27.8	19.6	18.9	63.4	23.5	52.6	100.0	0.0
Transitional housing history	27.2	33.3	40.9	33.3	21.8	35.3	23.5	11.8	35.5	44.4	25.5	34.0	48.8	29.6	60.5	0.0	100.0
Current work situation																	
Employed full-time	7.9	0.0	4.5	4.8	11.7	5.9	10.2	5.9	3.3	11.1	9.8	7.7	4.9	3.8	5.3	2.1	1.5
Employed part-time	12.0	22.2	9.1	4.8	13.0	23.5	16.3	0.0	6.7	27.8	17.6	17.3	9.8	13.9	5.3	14.6	13.4
Not working - looking for work	19.0	22.2	4.5	28.6	20.8	17.6	12.2	17.6	30.0	33.3	17.6	15.4	19.5	16.5	31.6	33.3	26.9
Not working - student/homemaker	12.8	11.1	9.1	19.0	7.8	17.6	22.4	11.8	6.7	16.7	7.8	36.5	7.3	8.9	10.5	6.3	16.4
Not working - not looking for work	38.8	33.3	59.1	38.1	31.2	29.4	34.7	52.9	50.0	11.1	41.2	21.2	53.7	48.1	39.5	37.5	35.8
Retired	9.5	11.1	13.6	4.8	15.6	5.9	4.1	11.8	3.3	0.0	5.9	1.9	4.9	8.9	7.9	6.3	6.0
Individual yearly income estimate																	
$8,600 or less	52.4	50.0	28.6	72.2	48.6	64.7	62.2	56.3	42.9	78.6	58.3	57.1	55.3	53.2	65.7	61.4	66.7
$8,601 - $11,600	28.4	37.5	42.9	16.7	25.0	35.3	20.0	25.0	42.9	7.1	25.0	20.4	31.6	33.8	25.7	25.0	27.0
$11,601 - $16,500	9.3	12.5	9.5	11.1	9.7	0.0	13.3	6.3	7.1	14.3	8.3	12.2	13.2	6.5	2.9	13.6	4.8
$16,501 - $23,200	2.7	0.0	4.8	0.0	4.2	0.0	2.2	6.3	0.0	0.0	2.1	4.1	0.0	1.3	2.9	0.0	1.6
$23,201 - $26,000	1.8	0.0	4.8	0.0	2.8	0.0	2.2	0.0	0.0	0.0	2.1	0.0	0.0	2.6	2.9	0.0	0.0
$26,001 - $35,000	2.2	0.0	0.0	0.0	5.6	0.0	0.0	6.3	0.0	0.0	2.1	0.0	0.0	1.3	0.0	0.0	0.0
Greater than $35,001	3.1	0.0	9.5	0.0	4.2	0.0	0.0	0.0	7.1	0.0	2.1	6.1	0.0	1.3	0.0	0.0	0.0

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	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Benefits Recevied																	
Food stamps	18.7	22.2	9.1	14.3	19.2	23.5	25.5	17.6	12.9	27.8	17.6	39.6	24.4	14.8	36.8	39.6	29.9
Long term disability	20.3	33.3	36.4	23.8	19.2	23.5	11.8	23.5	16.1	0.0	27.5	9.4	24.4	27.2	7.9	12.5	19.4
Short term disability	4.1	0.0	4.5	0.0	2.6	17.6	5.9	0.0	3.2	5.6	7.8	0.0	4.9	4.9	5.3	6.3	4.5
Supplemental Security Income (SSI)	39.4	55.6	36.4	42.9	28.2	64.7	43.1	41.2	41.9	11.1	35.3	32.1	39.0	44.4	23.7	27.1	34.3
Public Health Service, Bureau of Indian Affairs (BIA)	0.8	0.0	0.0	0.0	1.3	0.0	2.0	0.0	0.0	0.0	2.0	0.0	0.0	1.2	2.6	0.0	3.0
SDI	7.3	11.1	0.0	14.3	3.8	23.5	2.0	17.6	9.7	0.0	5.9	3.8	4.9	7.4	0.0	2.1	4.5
SSDI	22.0	22.2	31.8	23.8	17.9	41.2	13.7	29.4	22.6	0.0	27.5	5.7	19.5	37.0	13.2	14.6	17.9
VA Benefits	1.6	0.0	0.0	0.0	1.3	0.0	3.9	5.9	0.0	0.0	2.0	1.9	2.4	0.0	2.6	4.2	0.0
CHAMPUS	0.4	0.0	4.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Annuity/Life insurance payments	0.4	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.2	0.0	0.0	0.0
Retirement	4.9	11.1	9.1	0.0	10.3	5.9	0.0	0.0	0.0	5.6	3.9	0.0	2.4	1.2	0.0	2.1	1.5
Rent Supplement	11.4	33.3	9.1	0.0	10.3	23.5	15.7	11.8	3.2	11.1	13.7	13.2	9.8	12.3	0.0	4.2	9.0
Subsidized housing	33.3	22.2	13.6	19.0	41.0	29.4	33.3	47.1	35.5	22.2	33.3	41.5	39.0	43.2	7.9	39.6	31.3
General Assistance	9.3	11.1	13.6	4.8	10.3	17.6	3.9	11.8	9.7	0.0	9.8	7.5	22.0	12.3	28.9	27.1	16.4
Emergency Financial Assistance	2.4	0.0	0.0	0.0	2.6	0.0	5.9	5.9	0.0	5.6	3.9	3.8	0.0	3.7	0.0	4.2	3.0
WIC	5.7	0.0	4.5	0.0	9.0	0.0	9.8	5.9	0.0	16.7	3.9	17.0	2.4	3.7	5.3	4.2	9.0
TANF / CalWorks	7.7	0.0	9.1	9.5	6.4	0.0	15.7	11.8	0.0	16.7	9.8	30.2	4.9	7.4	7.9	12.5	6.0
% not eligible for benefits	14.6	0.0	23.5	0.0	28.9	10.0	3.4	10.0	5.3	9.1	12.8	5.9	11.5	17.6	7.7	6.5	11.6
Form of Health Insurance																	
Private insurance through work	6.9	0.0	4.5	0.0	11.5	5.9	3.9	5.9	9.7	11.1	5.9	3.8	2.4	3.7	5.3	4.2	1.5
COBRA or OBRA	1.2	0.0	0.0	0.0	0.0	0.0	2.0	0.0	6.5	0.0	2.0	1.9	0.0	1.2	2.6	2.1	0.0
Private insurance not through work	4.5	11.1	9.1	0.0	5.1	0.0	2.0	0.0	9.7	0.0	7.8	0.0	7.3	7.4	5.3	6.3	3.0
Medicare	25.6	55.6	36.4	33.3	19.2	41.2	15.7	23.5	29.0	0.0	25.5	7.5	19.5	35.8	15.8	12.5	23.9
Medi-Cal / Medicaid	52.0	44.4	36.4	61.9	46.2	58.8	60.8	64.7	48.4	22.2	54.9	50.9	46.3	61.7	31.6	37.5	43.3
% w/ health insurance	72.0	77.8	72.7	76.2	66.7	76.5	78.4	70.6	67.7	33.3	70.6	64.2	70.7	81.5	44.7	50.0	58.2
% w/o health insurance	28.0	22.2	27.3	23.8	33.3	23.5	21.6	29.4	32.3	66.7	29.4	35.8	29.3	18.5	55.3	50.0	41.8
Years w/ HIV																	
Less than 1 year	5.3	0.0	4.8	5.6	7.1	11.8	2.2	6.3	3.3	11.8	9.3	2.0	7.7	5.3	13.9	12.8	4.7
1 to 3 years	10.6	11.1	4.8	5.6	10.0	11.8	15.2	6.3	13.3	23.5	16.3	12.0	17.9	8.0	11.1	17.0	10.9
3 to 8 years	35.2	44.4	38.1	50.0	28.6	29.4	39.1	31.3	36.7	47.1	27.9	46.0	23.1	29.3	44.4	29.8	37.5
More than 8 years	48.9	44.4	52.4	38.9	54.3	47.1	43.5	56.3	46.7	17.6	46.5	40.0	51.3	57.3	30.6	40.4	46.9
Most likely way infected with HIV																	
Having sex with a man	65.2	44.4	63.6	42.9	70.1	64.7	74.0	52.9	67.7	55.6	74.0	78.8	58.5	67.9	60.5	64.6	62.7
Having sex with a woman	6.1	11.1	0.0	14.3	2.6	17.6	8.0	5.9	3.2	27.8	6.0	1.9	4.9	2.5	2.6	4.2	9.0
Having sex with a transgender	1.2	0.0	0.0	0.0	0.0	0.0	2.0	0.0	6.5	5.6	2.0	1.9	4.9	2.5	5.3	4.2	3.0
Sharing needles	13.5	11.1	27.3	19.0	16.9	11.8	2.0	17.6	9.7	0.0	0.0	3.8	26.8	17.3	21.1	22.9	16.4
Blood transfusions or products/Hemophilia	5.3	0.0	0.0	4.8	5.2	5.9	8.0	5.9	6.5	11.1	10.0	5.8	2.4	0.0	5.3	2.1	4.5
Acquired at birth	0.8	0.0	0.0	4.8	0.0	0.0	2.0	0.0	0.0	0.0	2.0	1.9	0.0	1.2	0.0	0.0	0.0
Other	0.4	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Don't know	7.4	33.3	9.1	14.3	3.9	0.0	4.0	17.6	6.5	0.0	6.0	5.8	2.4	8.6	5.3	2.1	4.5
Received AIDS diagnosis	54.5	44.4	45.5	57.1	59.0	47.1	54.9	52.9	54.8	50.0	45.1	49.1	31.7	60.5	28.9	33.3	44.8
Years w/ AIDS																	
Less than 3 years	29.0	25.0	10.0	18.2	31.8	62.5	28.6	44.4	17.6	25.0	34.8	23.1	46.2	25.0	36.4	50.0	28.6
3 to 6 years	31.3	25.0	20.0	45.5	25.0	12.5	42.9	33.3	35.3	62.5	34.8	38.5	23.1	20.8	27.3	18.8	35.7
6 to 12 years	35.1	50.0	70.0	36.4	38.6	0.0	25.0	22.2	41.2	12.5	21.7	34.6	30.8	50.0	36.4	31.3	28.6
More than 12 years	4.6	0.0	0.0	0.0	4.5	25.0	3.6	0.0	5.9	0.0	8.7	3.8	0.0	4.2	0.0	0.0	7.1
Physical health is...																	
Poor	9.5	22.2	4.5	5.0	11.7	11.8	8.0	17.6	3.2	11.1	12.0	5.7	7.3	7.4	5.3	10.4	3.0
Fair	36.6	33.3	40.9	70.0	37.7	11.8	32.0	35.3	32.3	38.9	36.0	32.1	29.3	40.7	42.1	29.2	40.3
Good	38.7	44.4	50.0	20.0	32.5	64.7	42.0	23.5	45.2	33.3	40.0	43.4	53.7	39.5	36.8	54.2	46.3
Excellent	15.2	0.0	4.5	5.0	18.2	11.8	18.0	23.5	19.4	16.7	12.0	18.9	9.8	12.3	15.8	6.3	10.4

Attachment 6 2002 Survey Demographics																	
	Total	Location								SPECIAL POPULATIONS							
	Sample	SPA1	SPA2	SPA3	SPA4	SPA5	SPA6	SPA7	SPA8	UNDOC	NON-IDU2	WCB (13-45yo)	REC INC	Severe MH	Current Hmls/ Trans	Hx of Hmls	Hx of Trans
	246	**9**	**22**	**21**	**78**	**17**	**51**	**17**	**31**	**18**	**51**	**53**	**41**	**81**	**38**	**48**	**67**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Compare your physical health																	
Much worse	6.6	0.0	9.1	0.0	6.5	5.9	8.3	5.9	9.7	0.0	8.2	7.7	2.4	8.8	13.2	4.2	4.5
A little worse	13.3	22.2	13.6	25.0	14.3	5.9	0.0	41.2	9.7	5.6	8.2	7.7	17.1	18.8	15.8	14.6	16.4
About the same	19.5	33.3	18.2	5.0	16.9	35.3	27.1	5.9	19.4	11.1	26.5	21.2	22.0	17.5	31.6	25.0	20.9
A little better	21.2	11.1	27.3	25.0	22.1	23.5	20.8	11.8	19.4	27.8	30.6	17.3	14.6	15.0	13.2	18.8	23.9
Much better	39.4	33.3	31.8	45.0	40.3	29.4	43.8	35.3	41.9	55.6	26.5	46.2	43.9	40.0	26.3	37.5	34.3
Emotional health is...																	
Poor	9.9	11.1	4.5	5.0	11.7	11.8	12.0	5.9	9.7	5.6	14.0	3.8	9.8	14.8	7.9	12.5	6.0
Fair	35.4	22.2	27.3	45.0	27.3	29.4	40.0	52.9	45.2	22.2	48.0	39.6	31.7	43.2	42.1	31.3	38.8
Good	37.9	55.6	50.0	40.0	41.6	47.1	28.0	23.5	32.3	55.6	32.0	30.2	46.3	35.8	36.8	45.8	44.8
Excellent	16.9	11.1	18.2	10.0	19.5	11.8	20.0	17.6	12.9	16.7	6.0	26.4	12.2	6.2	13.2	10.4	10.4
Compare your emotional health																	
Much worse	5.0	11.1	4.5	0.0	3.9	5.9	6.4	6.3	6.5	12.5	4.1	3.8	4.9	5.0	5.3	2.1	3.0
A little worse	12.2	0.0	18.2	5.0	11.8	5.9	14.9	18.8	12.9	0.0	12.2	11.5	7.3	17.5	5.3	12.5	6.0
About the same	18.9	33.3	13.6	30.0	17.1	29.4	10.6	25.0	19.4	6.3	18.4	13.5	29.3	21.3	28.9	20.8	28.4
A little better	24.8	22.2	18.2	30.0	21.1	29.4	34.0	18.8	22.6	37.5	36.7	23.1	22.0	23.8	28.9	25.0	25.4
Much better	39.1	33.3	45.5	35.0	46.1	29.4	34.0	31.3	38.7	43.8	28.6	48.1	36.6	32.5	31.6	39.6	37.3
Never seen a doctor since seroconversion	0.8	0.0	0.0	0.0	0.0	5.9	0.0	5.9	0.0	0.0	2.0	0.0	4.9	0.0	0.0	4.2	0.0
12 mos or longer w/out med care	21.1	22.2	31.8	19.0	23.1	23.5	17.6	23.5	12.9	33.3	15.7	17.0	39.0	27.2	31.6	35.4	22.4
6 mos or longer w/out med care	25.6	44.4	45.5	23.8	25.6	29.4	13.7	23.5	25.8	5.6	17.6	20.8	53.7	34.6	50.0	47.9	31.3
After which, went back & see a doc?	84.9	100.0	81.8	83.3	87.5	100.0	80.0	60.0	85.7	66.7	77.8	85.7	81.8	87.1	85.0	83.3	87.0
Reason for returning to doctor																	
Returned b/c I got sicker	15.1	22.2	22.7	14.3	14.1	25.0	11.8	11.8	12.9	0.0	14.0	9.4	27.5	23.5	26.3	27.7	16.4
Returned b/c change in my income	2.8	11.1	0.0	0.0	2.6	17.6	0.0	0.0	3.2	0.0	0.0	1.9	7.3	4.9	5.3	6.3	3.0
Returned b/c change in insurance	4.5	0.0	0.0	9.5	7.7	11.8	0.0	5.9	0.0	5.6	3.9	3.8	7.3	3.7	7.9	6.3	6.0
Returned b/c heard about new dr.	4.5	0.0	4.5	0.0	6.4	11.8	2.0	0.0	6.5	0.0	2.0	3.8	4.9	6.2	5.3	4.2	4.5
Returned b/c change in attitudes	4.1	0.0	0.0	0.0	5.1	5.9	3.9	0.0	9.7	11.1	2.0	3.8	9.8	6.2	2.6	4.2	3.0
Returned b/c new meds	6.5	0.0	18.2	4.8	3.8	17.6	3.9	0.0	9.7	0.0	2.0	5.7	14.6	8.6	5.3	10.4	9.0
Returned b/c had stable housing	7.3	11.1	9.1	9.5	3.8	17.6	3.9	5.9	12.9	0.0	2.0	9.4	17.1	9.9	23.7	20.8	11.9
STD Diagnosis in last year																	
Hepatitis A or B	15.9	22.2	18.2	19.0	15.4	29.4	13.7	0.0	16.1	33.3	9.8	11.3	26.8	19.8	18.4	25.0	16.4
Hepatitis C	15.0	11.1	22.7	14.3	16.7	17.6	9.8	23.5	9.7	11.1	5.9	5.7	24.4	23.5	28.9	25.0	16.4
Syphilis	7.3	11.1	0.0	14.3	5.1	5.9	7.8	0.0	16.1	11.1	0.0	5.7	7.3	4.9	5.3	10.4	9.0
Herpes (genital)	8.9	0.0	4.5	14.3	12.8	11.8	3.9	5.9	9.7	5.6	9.8	3.8	2.4	16.0	2.6	6.3	7.5
Gonorrhea	2.4	11.1	4.5	0.0	0.0	5.9	3.9	0.0	3.2	5.6	2.0	1.9	7.3	3.7	2.6	4.2	4.5
Chlamydia	4.1	0.0	4.5	4.8	1.3	5.9	9.8	0.0	3.2	5.6	3.9	9.4	7.3	6.2	5.3	10.4	7.5
Genital warts	8.1	0.0	0.0	9.5	12.8	11.8	7.8	0.0	6.5	11.1	9.8	11.3	2.4	14.8	7.9	8.3	11.9
Yeast infections	12.2	0.0	0.0	14.3	15.6	0.0	19.6	5.9	12.9	11.1	7.8	32.1	12.2	18.8	7.9	16.7	9.0
Taking antiretrovirals / protease inhibitors	61.8	77.8	77.3	66.7	55.1	76.5	52.9	52.9	71.0	55.6	60.8	64.2	68.3	66.7	47.4	58.3	61.2
Taking antibiotics	30.9	44.4	31.8	28.6	34.6	47.1	21.6	23.5	29.0	22.2	33.3	30.2	34.1	40.7	21.1	27.1	25.4
Skipped medications...																	
Never/ Have not skipped	32.6	12.5	35.0	35.0	33.3	50.0	34.1	40.0	17.2	23.5	30.4	27.1	23.1	31.1	28.1	25.0	29.5
Once or twice a month	32.6	62.5	25.0	30.0	34.7	25.0	34.1	26.7	31.0	35.3	28.3	33.3	23.1	36.5	21.9	18.2	29.5
Once or twice a week	14.5	0.0	20.0	15.0	11.1	12.5	17.1	13.3	20.7	5.9	23.9	14.6	28.2	9.5	15.6	27.3	18.0
More than twice a week	6.8	25.0	5.0	10.0	8.3	0.0	7.3	0.0	3.4	5.9	13.0	4.2	10.3	5.4	12.5	6.8	8.2
I have stopped taking my medicine	13.6	0.0	15.0	10.0	12.5	12.5	7.3	20.0	27.6	29.4	4.3	20.8	15.4	17.6	21.9	22.7	14.8
Reasons for skipping medications																	
Side effects	21.5	33.3	4.5	23.8	23.1	11.8	17.6	23.5	35.5	16.7	25.5	32.1	17.1	24.7	18.4	18.8	19.4
Difficult schedule	17.1	22.2	18.2	23.8	14.1	17.6	19.6	11.8	16.1	11.1	13.7	20.8	17.1	17.3	13.2	14.6	16.4
Didn't want others to see the meds	10.6	22.2	4.5	14.3	10.3	5.9	5.9	5.9	22.6	11.1	9.8	13.2	14.6	12.3	2.6	16.7	9.0
Didn't understand directions	5.3	11.1	0.0	4.8	6.4	11.8	2.0	5.9	6.5	5.6	5.9	3.8	7.3	8.6	5.3	6.3	9.0
Feel that medications didnt work	4.9	0.0	4.5	4.8	6.4	5.9	3.9	5.9	3.2	5.6	7.8	7.5	4.9	2.5	15.8	8.3	4.5

Attachment 6 2002 Survey Demographics																	
	Total	Location								SPECIAL POPULATIONS							
	Sample	SPA1	SPA2	SPA3	SPA4	SPA5	SPA6	SPA7	SPA8	UNDOC	NON-IDU2	WCB (13-45yo)	REC INC	Severe MH	Current Hmls/ Trans	Hx of Hmls	Hx of Trans
	246	**9**	**22**	**21**	**78**	**17**	**51**	**17**	**31**	**18**	**51**	**53**	**41**	**81**	**38**	**48**	**67**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Reasons for skipping medications (cont…)																	
Affordability	3.3	0.0	0.0	9.5	5.1	5.9	0.0	5.9	0.0	0.0	7.8	5.7	7.3	1.2	7.9	6.3	4.5
Forgot	38.2	55.6	45.5	33.3	41.0	35.3	25.5	29.4	51.6	33.3	43.1	35.8	48.8	44.4	34.2	45.8	40.3
Ran out	9.3	11.1	4.5	9.5	10.3	11.8	7.8	5.9	12.9	5.6	11.8	7.5	22.0	9.9	13.2	16.7	11.9
Hard to coordinate with food	15.1	11.1	13.6	19.0	16.9	5.9	13.7	17.6	16.1	27.8	17.6	13.5	17.1	17.3	18.4	14.6	12.1
Didn't want to take them	20.7	44.4	18.2	9.5	24.4	29.4	11.8	11.8	29.0	11.1	19.6	17.0	24.4	27.2	26.3	29.2	20.9
Homeless	7.7	22.2	4.5	0.0	6.4	23.5	3.9	0.0	16.1	5.6	7.8	5.7	22.0	11.1	26.3	27.1	13.4
Felt didn't need meds anymore	4.9	11.1	0.0	0.0	7.7	0.0	2.0	0.0	12.9	11.1	2.0	1.9	2.4	4.9	0.0	4.2	3.0
Doctor advised me to stop	8.5	0.0	4.5	9.5	9.0	0.0	3.9	11.8	22.6	11.1	5.9	17.0	4.9	12.3	5.3	10.4	6.0
Received mental health service	56.5	55.6	54.5	52.4	59.0	64.7	47.1	35.3	77.4	38.9	64.7	45.3	51.2	92.6	52.6	56.3	56.7
Inpatient (in a hospital at least overnight)	13.0	0.0	18.2	19.0	10.3	17.6	7.8	11.8	22.6	11.1	9.8	9.4	19.5	39.5	13.2	12.5	23.9
Individual counseling/therapy	50.4	33.3	45.5	61.9	52.6	52.9	39.2	41.2	67.7	22.2	51.0	45.3	39.0	80.2	50.0	52.1	55.2
Group counseling/therapy	37.4	22.2	45.5	28.6	41.0	41.2	27.5	47.1	41.9	11.1	33.3	30.2	41.5	53.1	36.8	41.7	43.3
Taken mental related medicines	28.5	11.1	45.5	14.3	35.9	35.3	13.7	23.5	35.5	5.6	31.4	9.4	31.7	80.2	34.2	35.4	26.9
In the last two years, received …																	
Anxiety diagnosis	34.1	33.3	18.2	23.8	35.9	47.1	27.5	23.5	58.1	22.2	33.3	24.5	29.3	61.7	34.2	31.3	29.9
Bipolar disorder	7.3	22.2	0.0	0.0	5.1	17.6	9.8	0.0	12.9	5.6	13.7	1.9	9.8	13.6	21.1	14.6	13.4
Dementia depression	2.8	0.0	0.0	0.0	3.8	0.0	5.9	5.9	0.0	5.6	3.9	1.9	2.4	4.9	0.0	0.0	1.5
Depression diagnosis	50.4	66.7	50.0	33.3	44.9	64.7	47.1	35.3	77.4	27.8	52.9	35.8	56.1	86.4	57.9	56.3	56.7
Alcohol																	
Not used in yr	56.1	66.7	45.5	71.4	51.3	52.9	62.7	70.6	45.2	44.4	29.4	62.3	36.6	49.4	44.7	43.8	50.7
Not used in last six months	6.5	0.0	18.2	0.0	5.1	5.9	7.8	11.8	3.2	33.3	3.9	9.4	12.2	6.2	2.6	10.4	11.9
Used in last 6 months	10.2	22.2	9.1	4.8	10.3	17.6	7.8	0.0	16.1	11.1	13.7	15.1	9.8	9.9	18.4	20.8	11.9
Used less than once a month	8.9	0.0	13.6	9.5	10.3	11.8	5.9	5.9	9.7	0.0	13.7	3.8	4.9	9.9	7.9	4.2	7.5
Used at least once a month	9.8	0.0	4.5	0.0	16.7	0.0	7.8	5.9	16.1	11.1	15.7	5.7	17.1	13.6	15.8	10.4	9.0
Used once a week or more	8.5	11.1	9.1	14.3	6.4	11.8	7.8	5.9	9.7	0.0	23.5	3.8	19.5	11.1	10.5	10.4	9.0
Marijuana																	
Not used in yr	68.7	77.8	54.5	76.2	69.2	52.9	72.5	82.4	64.5	72.2	35.3	83.0	46.3	64.2	65.8	56.3	64.2
Not used in last six months	4.1	0.0	18.2	0.0	2.6	0.0	3.9	5.9	3.2	22.2	2.0	1.9	9.8	3.7	0.0	6.3	7.5
Used in last 6 months	8.5	22.2	4.5	4.8	9.0	17.6	2.0	5.9	16.1	5.6	11.8	1.9	9.8	12.3	13.2	12.5	11.9
Used less than once a month	2.4	0.0	4.5	14.3	0.0	0.0	3.9	0.0	0.0	0.0	2.0	1.9	4.9	2.5	2.6	4.2	1.5
Used at least once a month	5.3	0.0	4.5	0.0	9.0	0.0	2.0	0.0	12.9	0.0	19.6	3.8	4.9	4.9	5.3	4.2	6.0
Used once a week or more	11.0	0.0	13.6	4.8	10.3	29.4	15.7	5.9	3.2	0.0	29.4	7.5	24.4	12.3	13.2	16.7	9.0
Crack																	
Not used in yr	84.1	77.8	63.6	95.2	88.5	82.4	88.2	94.1	71.0	72.2	64.7	92.5	65.9	76.5	65.8	66.7	70.1
Not used in last six months	4.5	0.0	18.2	0.0	2.6	0.0	5.9	5.9	3.2	22.2	5.9	3.8	12.2	6.2	2.6	8.3	7.5
Used in last 6 months	4.1	22.2	0.0	0.0	2.6	0.0	2.0	0.0	16.1	0.0	13.7	1.9	7.3	7.4	10.5	4.2	4.5
Used less than once a month	1.6	0.0	4.5	4.8	0.0	5.9	2.0	0.0	0.0	5.6	3.9	0.0	2.4	2.5	5.3	4.2	3.0
Used at least once a month	2.0	0.0	9.1	0.0	2.6	5.9	0.0	0.0	0.0	0.0	3.9	0.0	4.9	4.9	7.9	6.3	6.0
Used once a week or more	3.7	0.0	4.5	0.0	3.8	5.9	2.0	0.0	9.7	0.0	7.8	1.9	7.3	2.5	7.9	10.4	9.0
Heroin																	
Not used in yr	90.7	88.9	59.1	95.2	94.9	88.2	94.1	94.1	93.5	77.8	90.2	96.2	78.0	86.4	84.2	85.4	80.6
Not used in last six months	4.1	0.0	22.7	0.0	1.3	0.0	3.9	5.9	3.2	22.2	2.0	1.9	12.2	6.2	2.6	6.3	7.5
Used in last 6 months	2.8	11.1	0.0	0.0	3.8	11.8	0.0	0.0	3.2	0.0	3.9	0.0	0.0	4.9	2.6	0.0	4.5
Used less than once a month	0.8	0.0	4.5	0.0	0.0	0.0	2.0	0.0	0.0	0.0	2.0	0.0	2.4	1.2	2.6	2.1	1.5
Used at least once a month	0.8	0.0	9.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	4.9	1.2	2.6	4.2	3.0
Used once a week or more	0.8	0.0	4.5	4.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.9	2.4	0.0	5.3	2.1	3.0

Attachment 6 2002 Survey Demographics																	
	Total	Location								SPECIAL POPULATIONS							
	Sample	SPA1	SPA2	SPA3	SPA4	SPA5	SPA6	SPA7	SPA8	UNDOC	NON-IDU2	WCB (13-45yo)	REC INC	Severe MH	Current Hmls/ Trans	Hx of Hmls	Hx of Trans
	246	**9**	**22**	**21**	**78**	**17**	**51**	**17**	**31**	**18**	**51**	**53**	**41**	**81**	**38**	**48**	**67**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Crystal Meth																	
Not used in yr	82.5	88.9	54.5	90.5	80.8	76.5	94.1	88.2	80.6	72.2	74.5	94.3	63.4	70.4	65.8	62.5	73.1
Not used in last six months	3.7	0.0	18.2	0.0	1.3	0.0	3.9	5.9	3.2	22.2	2.0	1.9	12.2	3.7	2.6	6.3	6.0
Used in last 6 months	5.3	11.1	0.0	4.8	5.1	17.6	0.0	0.0	12.9	0.0	3.9	1.9	7.3	12.3	7.9	10.4	6.0
Used less than once a month	2.0	0.0	9.1	0.0	1.3	0.0	2.0	0.0	3.2	0.0	5.9	0.0	2.4	3.7	2.6	4.2	4.5
Used at least once a month	3.3	0.0	9.1	0.0	5.1	5.9	0.0	5.9	0.0	5.6	11.8	0.0	7.3	4.9	2.6	8.3	4.5
Used once a week or more	3.3	0.0	9.1	4.8	6.4	0.0	0.0	0.0	0.0	0.0	2.0	1.9	7.3	4.9	18.4	8.3	6.0
Speed																	
Not used in yr	92.7	100.0	72.7	100.0	96.2	82.4	94.1	94.1	93.5	77.8	92.2	96.2	87.8	87.7	89.5	89.6	85.1
Not used in last six months	4.5	0.0	27.3	0.0	1.3	0.0	3.9	5.9	3.2	22.2	2.0	3.8	12.2	7.4	7.9	8.3	10.4
Used in last 6 months	1.6	0.0	0.0	0.0	1.3	11.8	0.0	0.0	3.2	0.0	2.0	0.0	0.0	3.7	0.0	0.0	3.0
Used less than once a month	0.4	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0
Used at least once a month	0.4	0.0	0.0	0.0	0.0	5.9	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0
Used once a week or more	0.4	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.2	2.6	2.1	1.5
GHB																	
Not used in yr	93.5	100.0	77.3	100.0	96.2	94.1	94.1	94.1	90.3	77.8	94.1	96.2	87.8	90.1	94.7	93.8	89.6
Not used in last six months	4.1	0.0	22.7	0.0	1.3	0.0	3.9	5.9	3.2	22.2	2.0	3.8	9.8	6.2	5.3	6.3	9.0
Used in last 6 months	1.2	0.0	0.0	0.0	1.3	0.0	0.0	0.0	6.5	0.0	2.0	0.0	2.4	2.5	0.0	0.0	0.0
Used less than once a month	0.8	0.0	0.0	0.0	1.3	0.0	2.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0
Used once a week or more	0.4	0.0	0.0	0.0	0.0	5.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.2	0.0	0.0	1.5
Poppers																	
Not used in yr	87.0	100.0	68.2	95.2	85.9	82.4	94.1	94.1	80.6	77.8	78.4	96.2	75.6	81.5	78.9	81.3	80.6
Not used in last six months	4.1	0.0	27.3	0.0	1.3	0.0	3.9	0.0	3.2	22.2	0.0	3.8	9.8	6.2	5.3	8.3	10.4
Used in last 6 months	3.3	0.0	0.0	4.8	2.6	5.9	0.0	0.0	12.9	0.0	5.9	0.0	4.9	7.4	7.9	4.2	4.5
Used less than once a month	3.7	0.0	0.0	0.0	7.7	5.9	2.0	5.9	0.0	0.0	9.8	0.0	4.9	2.5	2.6	2.1	3.0
Used at least once a month	1.2	0.0	4.5	0.0	1.3	0.0	0.0	0.0	3.2	0.0	3.9	0.0	4.9	2.5	5.3	4.2	1.5
Used once a week or more	0.8	0.0	0.0	0.0	1.3	5.9	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0
Ecstasy																	
Not used in yr	91.5	100.0	72.7	100.0	92.3	88.2	92.2	94.1	93.5	77.8	88.2	96.2	85.4	88.9	86.8	91.7	88.1
Not used in last six months	4.5	0.0	27.3	0.0	1.3	0.0	3.9	5.9	3.2	22.2	2.0	3.8	12.2	7.4	7.9	8.3	10.4
Used in last 6 months	1.2	0.0	0.0	0.0	1.3	0.0	2.0	0.0	3.2	0.0	3.9	0.0	0.0	1.2	2.6	0.0	0.0
Used less than once a month	1.6	0.0	0.0	0.0	3.8	0.0	2.0	0.0	0.0	0.0	3.9	0.0	2.4	1.2	2.6	0.0	0.0
Used at least once a month	0.4	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Used once a week or more	0.8	0.0	0.0	0.0	0.0	11.8	0.0	0.0	0.0	0.0	2.0	0.0	0.0	1.2	0.0	0.0	1.5
Pills not prescribed by Dr.																	
Not used in yr	91.1	100.0	68.2	90.5	94.9	100.0	90.2	94.1	90.3	77.8	88.2	96.2	78.0	87.7	81.6	85.4	86.6
Not used in last six months	4.9	0.0	31.8	0.0	1.3	0.0	3.9	5.9	3.2	22.2	2.0	1.9	17.1	8.6	7.9	10.4	10.4
Used in last 6 months	2.0	0.0	0.0	4.8	1.3	0.0	3.9	0.0	3.2	0.0	7.8	0.0	0.0	2.5	2.6	0.0	1.5
Used at least once a month	1.6	0.0	0.0	4.8	1.3	0.0	2.0	0.0	3.2	0.0	2.0	1.9	2.4	1.2	5.3	4.2	1.5
Used once a week or more	0.4	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.4	0.0	2.6	0.0	0.0
Injected substance history	22.8	11.1	59.1	9.5	24.4	35.3	7.8	5.9	32.3	5.6	0.0	13.2	41.5	37.0	36.8	43.8	31.3
Country of origin																	
The United States	68.3	77.8	86.4	64.7	67.7	81.3	63.2	46.7	65.4	0.0	71.7	62.8	81.1	80.6	84.8	76.2	71.2
Mexico	12.5	0.0	4.5	5.9	10.8	12.5	15.8	46.7	7.7	70.6	6.5	25.6	10.8	5.6	6.1	14.3	18.6
Puerto Rico or other US Territories	1.4	11.1	0.0	5.9	0.0	0.0	0.0	0.0	3.8	0.0	2.2	0.0	2.7	1.4	0.0	2.4	1.7
Central America	7.2	0.0	0.0	5.9	10.8	0.0	13.2	6.7	3.8	23.5	4.3	9.3	2.7	6.9	3.0	4.8	5.1
Other	10.6	11.1	9.1	17.6	10.8	6.3	7.9	0.0	19.2	5.9	15.2	2.3	2.7	5.6	6.1	2.4	3.4
Citizenship status																	
Citizen	24.4	33.3	22.7	33.3	23.1	5.9	17.6	23.5	41.9	0.0	33.3	18.9	26.8	21.0	15.8	18.8	22.4
Have a visa (student, temp, or pemanent)	2.8	0.0	0.0	4.8	0.0	5.9	0.0	23.5	3.2	0.0	3.9	0.0	2.4	2.5	0.0	0.0	1.5
Have legal refugee or on asylum status	1.2	0.0	0.0	4.8	0.0	0.0	3.9	0.0	0.0	0.0	0.0	3.8	0.0	0.0	0.0	2.1	1.5
Undocumented	7.3	0.0	4.5	0.0	10.3	5.9	11.8	5.9	3.2	100.0	3.9	13.2	4.9	3.7	2.6	10.4	11.9
Other	1.2	0.0	0.0	0.0	2.6	0.0	2.0	0.0	0.0	0.0	3.9	0.0	0.0	0.0	2.6	0.0	0.0

Attachment 7 2002 Survey - Services Needed

Attachment 7 Services Needed																				
	Total	GENDER			ETHNICITY					RISKGRP							STAGE OF INFECTION			
	Sample	Male	Female	TG	Af Am	Anglo	API	Latino	Native Am	MSM Total	Af Am MSM	Anglo MSM	Latino MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
	246	**170**	**72**	**4**	**74**	**63**	**17**	**80**	**5**	**98**	**26**	**26**	**34**	**35**	**30**	**83**	**58**	**40**	**39**	**90**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Outpatient medical care	78.5	84.1	66.7	50.0	74.3	92.1	88.2	70.0	80.0	84.7	84.6	96.2	76.5	85.7	70.0	71.1	65.5	87.5	75.0	83.3
Med care w/ specialist	48.4	46.5	55.6	0.0	33.8	66.7	64.7	46.3	40.0	46.9	38.5	65.4	47.1	57.1	40.0	49.4	43.1	45.0	42.5	55.6
Nutrition Education	59.3	61.2	54.2	75.0	60.8	71.4	52.9	48.8	60.0	59.2	69.2	65.4	44.1	65.7	70.0	53.0	51.7	65.0	55.0	66.7
Dental care	66.7	68.8	62.5	50.0	60.8	85.7	76.5	53.8	60.0	65.3	61.5	88.5	50.0	85.7	73.3	57.8	60.3	67.5	72.5	70.0
Home health care	19.5	18.8	20.8	25.0	24.3	7.9	35.3	22.5	0.0	20.4	30.8	7.7	17.6	14.3	13.3	22.9	5.2	15.0	17.5	31.1
Hospice	11.8	11.2	12.5	25.0	18.9	4.8	29.4	7.5	0.0	16.3	30.8	0.0	8.8	8.6	3.3	10.8	5.2	15.0	5.0	17.8
Complementary care	20.7	20.0	23.6	0.0	17.6	25.4	41.2	13.8	60.0	23.5	15.4	26.9	17.6	20.0	20.0	18.1	22.4	15.0	17.5	23.3
Medication Reimbursement	52.8	61.2	31.9	75.0	50.0	61.9	76.5	43.8	60.0	67.3	76.9	69.2	50.0	51.4	63.3	32.5	46.6	60.0	40.0	64.4
Health insurance continuation	16.3	18.2	12.5	0.0	16.2	7.9	23.5	21.3	20.0	19.4	23.1	7.7	23.5	25.7	6.7	12.0	12.1	5.0	17.5	22.2
Van transportation	42.7	40.0	47.2	75.0	45.9	34.9	41.2	46.3	60.0	43.9	61.5	30.8	38.2	42.9	40.0	42.2	37.9	55.0	22.5	47.8
Taxi Vouchers	62.2	59.4	69.4	50.0	70.3	52.4	64.7	58.8	80.0	53.1	73.1	38.5	44.1	68.6	73.3	66.3	65.5	72.5	40.0	65.6
Residential mental health srvcs	24.4	26.5	19.4	25.0	28.4	19.0	41.2	18.8	40.0	22.4	38.5	0.0	17.6	45.7	20.0	19.3	27.6	25.0	17.5	25.6
Ind. or Grp. Therapy Session	54.1	54.7	50.0	100.0	58.1	55.6	47.1	47.5	80.0	59.2	57.7	61.5	55.9	65.7	53.3	43.4	51.7	50.0	50.0	61.1
Peer Counseling	54.5	52.4	59.7	50.0	58.1	49.2	64.7	52.5	60.0	51.0	57.7	42.3	44.1	65.7	46.7	56.6	58.6	52.5	42.5	58.9
Outpatient substance counseling	22.4	27.1	11.1	25.0	25.7	23.8	17.6	16.3	20.0	17.3	30.8	7.7	17.6	60.0	23.3	12.0	20.7	32.5	12.5	22.2
Residential Substance Counseling	12.6	15.3	5.6	25.0	17.6	15.9	11.8	5.0	20.0	6.1	19.2	0.0	2.9	40.0	20.0	6.0	15.5	15.0	5.0	12.2
Detox/Methadone maintenance	9.8	11.2	6.9	0.0	6.8	7.9	11.8	11.3	20.0	6.1	3.8	3.8	8.8	22.9	13.3	7.2	5.2	15.0	0.0	14.4
Medical Case Mgmt	47.6	48.2	45.8	50.0	43.2	52.4	64.7	43.8	60.0	44.9	50.0	34.6	41.2	60.0	60.0	41.0	39.7	52.5	40.0	51.1
Case management	64.6	68.2	55.6	75.0	54.1	79.4	88.2	55.0	80.0	67.3	65.4	69.2	61.8	80.0	73.3	51.8	67.2	75.0	50.0	70.0
Employment assistance	26.4	29.4	16.7	75.0	29.7	30.2	23.5	21.3	0.0	26.5	34.6	23.1	17.6	42.9	40.0	14.5	34.5	27.5	22.5	25.6
Housing Info Srvcs	53.7	56.5	44.4	100.0	58.1	50.8	64.7	47.5	60.0	55.1	69.2	34.6	50.0	68.6	66.7	41.0	55.2	57.5	42.5	58.9
Rental assistance	41.9	48.2	27.8	25.0	43.2	50.8	52.9	28.8	40.0	40.8	53.8	26.9	35.3	68.6	50.0	28.9	43.1	47.5	40.0	41.1
Independent housing	61.0	62.4	55.6	100.0	64.9	65.1	88.2	48.8	40.0	67.3	76.9	61.5	58.8	74.3	63.3	47.0	55.2	75.0	55.0	64.4
Supportive housing	15.0	17.1	9.7	25.0	17.6	19.0	17.6	7.5	20.0	13.3	19.2	7.7	11.8	31.4	23.3	7.2	15.5	22.5	5.0	15.6
Transitional housing	24.8	27.1	19.4	25.0	29.7	28.6	11.8	16.3	20.0	21.4	38.5	3.8	17.6	42.9	46.7	13.3	29.3	30.0	17.5	22.2
Food pantry	66.7	65.3	68.1	100.0	70.3	73.0	76.5	56.3	60.0	56.1	57.7	61.5	50.0	85.7	76.7	67.5	58.6	87.5	62.5	64.4
Food Vouchers	59.8	56.5	65.3	100.0	70.3	47.6	64.7	56.3	80.0	48.0	57.7	30.8	47.1	68.6	73.3	65.1	60.3	75.0	47.5	54.4
Home delivered meals	34.1	34.7	30.6	75.0	33.8	38.1	41.2	27.5	40.0	29.6	30.8	26.9	29.4	51.4	43.3	28.9	29.3	55.0	17.5	36.7
Prevention	45.5	42.4	52.8	50.0	52.7	44.4	58.8	35.0	80.0	40.8	53.8	34.6	26.5	51.4	53.3	45.8	48.3	52.5	37.5	43.3
DEFA	49.6	48.8	50.0	75.0	56.8	46.0	70.6	40.0	40.0	43.9	50.0	30.8	41.2	57.1	66.7	47.0	53.4	65.0	35.0	48.9
Legal Services	36.6	37.1	33.3	75.0	39.2	47.6	35.3	26.3	40.0	36.7	38.5	42.3	35.3	54.3	33.3	30.1	34.5	37.5	27.5	44.4
Adult day care	8.1	7.6	8.3	25.0	12.2	4.8	11.8	6.3	0.0	6.1	11.5	0.0	5.9	11.4	6.7	9.6	5.2	5.0	7.5	11.1
Day Care	12.6	6.5	27.8	0.0	13.5	7.9	11.8	15.0	0.0	3.1	7.7	0.0	2.9	5.7	26.7	21.7	12.1	20.0	10.0	8.9

Attachment 7 Services Needed																	
	Total	Location								SPECIAL POPULATIONS							
	Sample	SPA1	SPA2	SPA3	SPA4	SPA5	SPA6	SPA7	SPA8	UNDOC	NON-IDU2	WCB (13-45yo)	REC INC	Severe MH	Current Hmls/ Trans	Hx of Hmls	Hx of Trans
	246	**9**	**22**	**21**	**78**	**17**	**51**	**17**	**31**	**18**	**51**	**53**	**41**	**81**	**38**	**48**	**67**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Outpatient medical care	78.5	100.0	81.8	76.2	82.1	76.5	74.5	76.5	71.0	66.7	76.5	62.3	78.0	81.5	76.3	70.8	73.1
Med care w/ specialist	48.4	11.1	63.6	42.9	52.6	70.6	43.1	35.3	45.2	50.0	49.0	50.9	34.1	54.3	39.5	45.8	43.3
Nutrition Education	59.3	77.8	54.5	71.4	61.5	58.8	47.1	41.2	74.2	44.4	62.7	45.3	63.4	64.2	55.3	62.5	56.7
Dental care	66.7	77.8	81.8	61.9	64.1	76.5	52.9	58.8	83.9	50.0	60.8	64.2	75.6	76.5	71.1	79.2	71.6
Home health care	19.5	33.3	0.0	14.3	20.5	17.6	25.5	29.4	16.1	0.0	25.5	18.9	12.2	16.0	10.5	12.5	19.4
Hospice	11.8	11.1	0.0	19.0	12.8	5.9	13.7	5.9	16.1	5.6	17.6	9.4	9.8	11.1	7.9	10.4	9.0
Complementary care	20.7	0.0	22.7	14.3	29.5	11.8	21.6	5.9	19.4	0.0	25.5	24.5	19.5	22.2	26.3	20.8	20.9
Medication Reimbursement	52.8	77.8	72.7	47.6	51.3	52.9	33.3	64.7	64.5	44.4	49.0	34.0	63.4	61.7	68.4	64.6	53.7
Health insurance continuation	16.3	22.2	13.6	19.0	16.7	5.9	13.7	29.4	16.1	11.1	13.7	11.3	7.3	14.8	7.9	8.3	17.9
Van transportation	42.7	44.4	36.4	47.6	42.3	47.1	47.1	35.3	38.7	55.6	52.9	49.1	56.1	48.1	50.0	50.0	59.7
Taxi Vouchers	62.2	77.8	68.2	81.0	44.9	76.5	72.5	52.9	64.5	50.0	74.5	69.8	82.9	66.7	73.7	83.3	73.1
Residential mental health srvcs	24.4	11.1	40.9	28.6	12.8	41.2	27.5	11.8	35.5	16.7	25.5	17.0	26.8	33.3	42.1	35.4	34.3
Ind. or Grp. Therapy Session	54.1	66.7	54.5	38.1	50.0	58.8	56.9	47.1	67.7	44.4	68.6	47.2	63.4	76.5	47.4	66.7	59.7
Peer Counseling	54.5	55.6	63.6	33.3	51.3	58.8	58.8	47.1	64.5	50.0	56.9	56.6	61.0	61.7	57.9	60.4	70.1
Outpatient substance counseling	22.4	22.2	40.9	19.0	23.1	29.4	11.8	11.8	29.0	11.1	25.5	11.3	41.5	38.3	39.5	43.8	37.3
Residential Substance Counseling	12.6	11.1	31.8	14.3	11.5	11.8	7.8	5.9	12.9	0.0	13.7	5.7	19.5	18.5	31.6	22.9	29.9
Detox/Methadone maintenance	9.8	11.1	13.6	14.3	10.3	11.8	3.9	17.6	6.5	0.0	5.9	7.5	17.1	14.8	18.4	16.7	17.9
Medical Case Mgmt	47.6	33.3	50.0	47.6	47.4	52.9	37.3	47.1	64.5	50.0	51.0	39.6	46.3	59.3	36.8	50.0	49.3
Case management	64.6	66.7	72.7	76.2	55.1	82.4	54.9	58.8	83.9	50.0	70.6	54.7	78.0	76.5	81.6	77.1	71.6
Employment assistance	26.4	22.2	31.8	23.8	24.4	23.5	23.5	17.6	41.9	22.2	27.5	17.0	46.3	33.3	42.1	45.8	28.4
Housing Info Srvcs	53.7	44.4	59.1	57.1	48.7	52.9	47.1	58.8	71.0	61.1	60.8	43.4	75.6	59.3	84.2	87.5	65.7
Rental assistance	41.9	44.4	50.0	47.6	37.2	41.2	29.4	47.1	61.3	27.8	54.9	26.4	56.1	50.6	55.3	58.3	49.3
Independent housing	61.0	22.2	68.2	57.1	59.0	58.8	47.1	70.6	93.5	55.6	70.6	58.5	78.0	71.6	81.6	77.1	65.7
Supportive housing	15.0	11.1	36.4	4.8	7.7	23.5	11.8	11.8	29.0	16.7	15.7	9.4	31.7	18.5	23.7	25.0	23.9
Transitional housing	24.8	44.4	31.8	19.0	16.7	41.2	23.5	5.9	41.9	27.8	27.5	17.0	53.7	28.4	60.5	54.2	40.3
Food pantry	66.7	66.7	59.1	90.5	62.8	76.5	56.9	64.7	77.4	61.1	78.4	66.0	75.6	76.5	78.9	83.3	71.6
Food Vouchers	59.8	55.6	63.6	57.1	48.7	64.7	68.6	52.9	74.2	77.8	68.6	64.2	75.6	71.6	68.4	79.2	70.1
Home delivered meals	34.1	33.3	50.0	38.1	29.5	41.2	27.5	23.5	45.2	27.8	41.2	30.2	56.1	43.2	44.7	52.1	43.3
Prevention	45.5	22.2	40.9	42.9	37.2	58.8	51.0	41.2	64.5	38.9	49.0	47.2	53.7	46.9	47.4	54.2	44.8
DEFA	49.6	66.7	59.1	47.6	42.3	35.3	47.1	47.1	71.0	66.7	52.9	50.9	61.0	59.3	57.9	58.3	50.7
Legal Services	36.6	33.3	36.4	14.3	39.7	47.1	35.3	35.3	41.9	44.4	43.1	32.1	46.3	48.1	34.2	50.0	41.8
Adult day care	8.1	0.0	4.5	4.8	6.4	5.9	11.8	11.8	12.9	11.1	11.8	7.5	7.3	3.7	5.3	10.4	10.4
Day Care	12.6	0.0	22.7	4.8	9.0	11.8	21.6	0.0	16.1	27.8	9.8	34.0	17.1	8.6	10.5	12.5	14.9

Attachment 8 2002 Survey - Services Asked

Attachment 8 Services Asked																					
	Total	GENDER			ETHNICITY					RISKGRP							STAGE OF INFECTION				Location
	Sample	Male	Female	TG	Af Am	Anglo	API	Latino	Native Am	MSM Total	Af Am MSM	Anglo MSM	Latino MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp	SPA1
	246	**170**	**72**	**4**	**74**	**63**	**17**	**80**	**5**	**98**	**26**	**26**	**34**	**35**	**30**	**83**	**58**	**40**	**39**	**90**	**9**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Outpatient Medical Care	59.6	65.9	45.1	50.0	35.6	85.7	70.6	56.3	80.0	64.3	50.0	88.5	52.9	77.1	53.3	48.8	50.0	56.4	60.0	67.8	55.6
Med care w/ specialist	39.8	37.6	47.2	0.0	25.7	61.9	41.2	35.0	40.0	35.7	30.8	57.7	32.4	57.1	23.3	43.4	32.8	35.0	32.5	51.1	11.1
Nutrition Education	45.9	48.8	38.9	50.0	45.9	60.3	47.1	32.5	40.0	48.0	57.7	53.8	35.3	57.1	46.7	38.6	37.9	52.5	50.0	50.0	55.6
Dental care	54.1	58.2	44.4	50.0	44.6	79.4	58.8	38.8	80.0	57.1	57.7	88.5	32.4	71.4	63.3	39.8	51.7	47.5	52.5	62.2	33.3
Home health care	15.0	12.9	18.1	50.0	16.2	9.5	35.3	15.0	0.0	15.3	19.2	7.7	11.8	11.4	13.3	16.9	6.9	12.5	10.0	24.4	22.2
Hospice	7.7	5.3	12.5	25.0	8.1	4.8	23.5	6.3	0.0	9.2	11.5	0.0	5.9	0.0	6.7	9.6	6.9	10.0	2.5	11.1	0.0
Complementary care	15.9	15.9	16.7	0.0	12.2	20.6	41.2	8.8	40.0	17.3	11.5	23.1	8.8	17.1	16.7	13.3	15.5	12.5	12.5	18.9	0.0
Medication Reimbursement	43.1	48.8	30.6	25.0	39.2	50.8	64.7	35.0	60.0	52.0	57.7	50.0	38.2	45.7	43.3	31.3	37.9	52.5	40.0	47.8	66.7
Health insurance continuation	10.2	11.2	8.3	0.0	10.8	6.3	17.6	10.0	20.0	9.2	11.5	3.8	8.8	20.0	3.3	9.6	6.9	2.5	10.0	16.7	11.1
Van transportation	31.3	29.4	36.1	25.0	31.1	30.2	35.3	32.5	40.0	34.7	42.3	30.8	26.5	25.7	30.0	30.1	31.0	40.0	17.5	37.8	22.2
Taxi Vouchers	48.4	48.2	50.0	25.0	48.6	47.6	52.9	43.8	80.0	41.8	57.7	30.8	35.3	57.1	70.0	44.6	53.4	60.0	32.5	52.2	66.7
Residential mental health srvcs	17.9	22.4	6.9	25.0	20.3	14.3	23.5	13.8	40.0	20.4	38.5	0.0	17.6	37.1	16.7	7.2	24.1	17.5	12.5	16.7	11.1
Ind. or Grp. Therapy Session	43.1	47.6	30.6	75.0	41.9	49.2	41.2	36.3	60.0	50.0	50.0	53.8	47.1	62.9	43.3	26.5	43.1	40.0	40.0	48.9	44.4
Peer Counseling	39.4	39.4	38.9	50.0	37.8	42.9	52.9	32.5	40.0	36.7	38.5	30.8	29.4	62.9	33.3	34.9	41.4	40.0	35.0	44.4	55.6
Outpatient substance counseling	17.9	21.8	8.3	25.0	20.3	19.0	17.6	11.3	20.0	13.3	26.9	3.8	11.8	51.4	23.3	7.2	10.3	32.5	12.5	18.9	11.1
Residential Substance Counseling	9.8	12.4	2.8	25.0	10.8	15.9	11.8	2.5	20.0	4.1	11.5	3.8	0.0	34.3	20.0	2.4	6.9	15.0	5.0	12.2	0.0
Detox/Methadone maintenance	8.1	10.0	4.2	0.0	4.1	9.5	11.8	7.5	20.0	4.1	0.0	3.8	5.9	22.9	13.3	4.8	1.7	17.5	0.0	12.2	11.1
Medical Case Mgmt	36.1	35.5	36.6	50.0	29.2	39.7	52.9	33.8	60.0	32.7	34.6	23.1	29.4	50.0	46.7	30.5	31.0	46.2	35.0	37.8	33.3
Case management	56.9	60.6	47.2	75.0	45.9	71.4	82.4	46.3	80.0	57.1	57.7	57.7	50.0	77.1	70.0	43.4	60.3	70.0	40.0	62.2	55.6
Employment assistance	19.1	22.9	9.7	25.0	21.6	20.6	29.4	12.5	0.0	22.4	23.1	19.2	14.7	28.6	23.3	9.6	24.1	20.0	15.0	20.0	22.2
Housing Info Srvcs	43.9	48.2	31.9	75.0	43.2	44.4	64.7	37.5	40.0	45.9	57.7	30.8	38.2	60.0	63.3	27.7	44.8	55.0	30.0	47.8	44.4
Rental assistance	32.1	38.2	18.1	25.0	28.4	41.3	47.1	21.3	40.0	29.6	38.5	19.2	23.5	60.0	43.3	19.3	31.0	40.0	27.5	32.2	44.4
Independent housing	52.8	54.1	48.6	75.0	52.7	57.1	88.2	42.5	20.0	56.1	57.7	61.5	44.1	65.7	56.7	42.2	48.3	60.0	52.5	56.7	22.2
Supportive housing	11.8	14.1	6.9	0.0	14.9	17.5	11.8	2.5	20.0	8.2	11.5	7.7	2.9	28.6	26.7	3.6	13.8	22.5	7.5	8.9	0.0
Transitional housing	21.1	24.7	13.9	0.0	25.7	27.0	17.6	8.8	20.0	17.3	30.8	7.7	8.8	37.1	43.3	10.8	24.1	25.0	20.0	20.0	22.2
Food pantry	54.9	54.7	54.2	75.0	54.1	66.7	70.6	43.8	20.0	48.0	50.0	57.7	38.2	80.0	63.3	49.4	53.4	67.5	55.0	55.6	44.4
Food Vouchers	45.1	44.1	47.2	50.0	47.3	36.5	64.7	42.5	60.0	38.8	46.2	23.1	35.3	57.1	53.3	44.6	46.6	52.5	35.0	44.4	33.3
Home delivered meals	27.6	30.0	20.8	50.0	27.0	31.7	29.4	21.3	40.0	26.5	30.8	23.1	26.5	45.7	40.0	16.9	25.9	42.5	15.0	30.0	22.2
Prevention	39.8	38.2	43.1	50.0	48.6	39.7	41.2	28.8	80.0	37.8	53.8	30.8	23.5	51.4	43.3	36.1	50.0	45.0	27.5	38.9	33.3
DEFA	33.3	35.3	27.8	50.0	37.8	33.3	58.8	21.3	40.0	32.7	38.5	26.9	23.5	42.9	43.3	26.5	32.8	45.0	20.0	37.8	44.4
Legal Services	24.8	27.1	19.4	25.0	20.3	34.9	23.5	21.3	20.0	29.6	19.2	42.3	29.4	34.3	16.7	18.1	22.4	27.5	17.5	33.3	22.2
Adult Day Care	5.7	4.7	6.9	25.0	8.1	4.8	5.9	3.8	0.0	3.1	7.7	0.0	2.9	8.6	6.7	7.2	3.4	5.0	5.0	8.9	0.0
Day care	7.7	3.5	18.1	0.0	9.5	4.8	5.9	7.5	0.0	2.0	3.8	0.0	2.9	2.9	16.7	13.3	5.2	15.0	10.0	4.4	0.0

Attachment 8 Services Asked																
	Total								SPECIAL POPULATIONS							
	Sample	SPA2	SPA3	SPA4	SPA5	SPA6	SPA7	SPA8	UNDOC	NON-IDU2	WCB (13-45yo)	REC INC	Severe MH	Current Hmls/ Trans	Hx of Hmls	Hx of Trans
	246	**22**	**21**	**78**	**17**	**51**	**17**	**31**	**18**	**51**	**53**	**41**	**81**	**38**	**48**	**67**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Outpatient Medical Care	59.6	63.6	70.0	69.2	76.5	39.2	58.8	51.6	55.6	60.8	44.2	58.5	70.4	67.6	53.2	59.1
Med care w/ specialist	39.8	59.1	28.6	43.6	70.6	37.3	23.5	29.0	38.9	35.3	47.2	26.8	43.2	34.2	35.4	38.8
Nutrition Education	45.9	45.5	61.9	46.2	35.3	35.3	29.4	64.5	22.2	54.9	35.8	53.7	56.8	47.4	47.9	49.3
Dental care	54.1	59.1	66.7	56.4	58.8	41.2	41.2	67.7	33.3	49.0	45.3	63.4	65.4	52.6	64.6	52.2
Home health care	15.0	0.0	9.5	16.7	11.8	21.6	11.8	16.1	5.6	15.7	20.8	9.8	14.8	7.9	6.3	16.4
Hospice	7.7	0.0	9.5	9.0	11.8	9.8	0.0	9.7	5.6	9.8	13.2	4.9	7.4	7.9	6.3	7.5
Complementary care	15.9	22.7	9.5	23.1	0.0	13.7	5.9	19.4	0.0	13.7	18.9	12.2	17.3	18.4	10.4	16.4
Medication Reimbursement	43.1	59.1	38.1	46.2	41.2	29.4	35.3	48.4	38.9	45.1	34.0	58.5	53.1	65.8	60.4	52.2
Health insurance continuation	10.2	4.5	14.3	14.1	5.9	7.8	11.8	6.5	5.6	5.9	7.5	2.4	7.4	5.3	6.3	13.4
Van transportation	31.3	31.8	28.6	30.8	29.4	35.3	29.4	32.3	38.9	35.3	37.7	31.7	37.0	26.3	31.3	35.8
Taxi Vouchers	48.4	63.6	52.4	34.6	70.6	47.1	41.2	58.1	38.9	56.9	54.7	68.3	58.0	60.5	68.8	55.2
Residential mental health srvcs	17.9	40.9	9.5	9.0	29.4	17.6	17.6	25.8	11.1	23.5	3.8	19.5	28.4	31.6	27.1	26.9
Ind. or Grp. Therapy Session	43.1	54.5	33.3	39.7	52.9	37.3	35.3	58.1	33.3	54.9	32.1	53.7	69.1	42.1	60.4	49.3
Peer Counseling	39.4	54.5	28.6	32.1	47.1	35.3	29.4	58.1	38.9	37.3	39.6	41.5	51.9	44.7	45.8	50.7
Outpatient substance counseling	17.9	40.9	19.0	16.7	17.6	9.8	0.0	29.0	5.6	13.7	9.4	39.0	32.1	28.9	35.4	29.9
Residential Substance Counseling	9.8	31.8	14.3	7.7	11.8	5.9	0.0	9.7	0.0	7.8	3.8	17.1	16.0	23.7	18.8	23.9
Detox/Methadone maintenance	8.1	18.2	14.3	6.4	11.8	3.9	5.9	6.5	0.0	2.0	5.7	17.1	14.8	18.4	14.6	16.4
Medical Case Mgmt	36.1	52.4	38.1	32.1	35.3	32.0	35.3	41.9	44.4	35.3	36.5	32.5	47.5	30.6	36.2	31.8
Case management	56.9	68.2	66.7	48.7	76.5	43.1	52.9	77.4	50.0	56.9	49.1	73.2	70.4	78.9	72.9	68.7
Employment assistance	19.1	22.7	19.0	19.2	23.5	13.7	5.9	29.0	5.6	19.6	9.4	34.1	24.7	34.2	29.2	22.4
Housing Info Srvcs	43.9	59.1	47.6	34.6	52.9	33.3	41.2	67.7	44.4	52.9	34.0	63.4	54.3	78.9	79.2	64.2
Rental assistance	32.1	50.0	42.9	24.4	35.3	23.5	29.4	41.9	16.7	37.3	18.9	46.3	42.0	34.2	43.8	37.3
Independent housing	52.8	54.5	47.6	52.6	52.9	43.1	52.9	80.6	44.4	56.9	50.9	58.5	65.4	68.4	62.5	61.2
Supportive housing	11.8	40.9	0.0	6.4	11.8	9.8	0.0	25.8	5.6	9.8	7.5	26.8	14.8	23.7	22.9	23.9
Transitional housing	21.1	36.4	19.0	11.5	35.3	21.6	0.0	38.7	22.2	21.6	13.2	41.5	24.7	52.6	50.0	37.3
Food pantry	54.9	50.0	66.7	51.3	64.7	49.0	52.9	67.7	44.4	58.8	50.9	56.1	70.4	60.5	70.8	59.7
Food Vouchers	45.1	54.5	42.9	33.3	47.1	54.9	35.3	61.3	55.6	49.0	47.2	53.7	59.3	47.4	54.2	53.7
Home delivered meals	27.6	45.5	38.1	24.4	29.4	19.6	11.8	38.7	16.7	37.3	18.9	46.3	40.7	39.5	41.7	35.8
Prevention	39.8	45.5	19.0	32.1	58.8	45.1	23.5	61.3	33.3	47.1	37.7	48.8	44.4	44.7	50.0	40.3
DEFA	33.3	45.5	33.3	29.5	35.3	23.5	29.4	48.4	27.8	37.3	24.5	43.9	44.4	36.8	37.5	29.9
Legal Services	24.8	22.7	9.5	29.5	29.4	23.5	17.6	29.0	27.8	27.5	17.0	26.8	35.8	26.3	35.4	26.9
Adult Day Care	5.7	4.5	4.8	3.8	0.0	9.8	5.9	9.7	5.6	5.9	5.7	4.9	3.7	2.6	6.3	9.0
Day care	7.7	13.6	4.8	5.1	0.0	17.6	0.0	6.5	22.2	7.8	22.6	9.8	7.4	7.9	8.3	7.5

Attachment 9 2002 Survey - Services Received

Attachment 9 Services Received																					
	Total	GENDER			ETHNICITY					RISKGRP							STAGE OF INFECTION				Location
	Sample	Male	Female	TG	Af Am	Anglo	API	Latino	Native Am	MSM Total	Af Am MSM	Anglo MSM	Latino MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp	SPA1
	246	**170**	**72**	**4**	**74**	**63**	**17**	**80**	**5**	**98**	**26**	**26**	**34**	**35**	**30**	**83**	**58**	**40**	**39**	**90**	**9**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Outpatient Medical Care	68.3	72.4	59.7	50.0	48.6	87.3	82.4	67.5	80.0	72.4	61.5	92.3	64.7	80.0	63.3	60.2	63.8	67.5	75.0	70.0	66.7
med care w/ specialist	41.9	40.6	47.2	0.0	29.7	65.1	41.2	35.0	40.0	42.9	46.2	61.5	35.3	51.4	36.7	38.6	34.5	42.5	45.0	47.8	22.2
Nutrition Education	44.3	48.8	33.3	50.0	36.5	66.7	47.1	31.3	40.0	52.0	53.8	65.4	38.2	54.3	46.7	30.1	39.7	52.5	42.5	50.0	66.7
Dental care	48.8	52.4	40.3	50.0	36.5	73.0	58.8	37.5	40.0	52.0	46.2	84.6	35.3	68.6	46.7	37.3	43.1	57.5	57.5	48.9	22.2
Home health care	11.8	11.8	11.1	25.0	10.8	7.9	23.5	13.8	0.0	13.3	15.4	7.7	11.8	8.6	10.0	12.0	6.9	7.5	12.5	16.7	11.1
Hospice	5.7	5.3	5.6	25.0	6.8	0.0	23.5	5.0	0.0	9.2	11.5	0.0	5.9	0.0	0.0	6.0	6.9	7.5	2.5	6.7	0.0
Complementary care	12.2	13.5	9.7	0.0	8.1	15.9	23.5	10.0	20.0	18.4	15.4	19.2	14.7	5.7	13.3	7.2	15.5	15.0	5.0	12.2	0.0
Medication Reimbursement	45.9	52.4	30.6	50.0	35.1	54.0	70.6	43.8	60.0	57.1	57.7	57.7	44.1	45.7	53.3	30.1	41.4	50.0	47.5	51.1	77.8
Health insurance continuation	9.4	9.5	9.7	0.0	5.5	6.3	11.8	13.8	20.0	8.2	3.8	3.8	11.8	17.6	3.3	9.6	8.8	2.5	12.5	13.3	11.1
Van transportation	24.8	23.5	26.4	50.0	23.0	22.2	17.6	31.3	20.0	30.6	30.8	26.9	32.4	17.1	20.0	22.9	25.9	25.0	17.5	28.9	33.3
Taxi Vouchers	45.5	44.7	48.6	25.0	39.2	44.4	47.1	47.5	80.0	39.8	38.5	34.6	41.2	51.4	63.3	43.4	51.7	52.5	35.0	47.8	66.7
Residential mental health srvcs	12.6	15.9	4.2	25.0	14.9	6.3	17.6	10.0	40.0	14.3	23.1	0.0	11.8	20.0	16.7	6.0	15.5	15.0	10.0	10.0	22.2
Ind. or Grp. Therapy Session	41.5	45.3	30.6	75.0	37.8	46.0	47.1	35.0	80.0	50.0	42.3	53.8	44.1	51.4	53.3	22.9	41.4	35.0	37.5	48.9	44.4
Peer Counseling	42.0	43.2	38.9	50.0	39.7	44.4	64.7	35.0	40.0	41.2	40.0	34.6	35.3	65.7	36.7	34.9	47.4	40.0	35.0	47.8	55.6
Outpatient substance counseling	16.7	20.0	8.3	25.0	17.6	17.5	17.6	12.5	20.0	12.2	19.2	7.7	14.7	48.6	20.0	7.2	12.1	32.5	12.5	15.6	0.0
Residential Substance Counseling	8.1	10.0	2.8	25.0	10.8	11.1	5.9	2.5	20.0	2.0	7.7	0.0	0.0	28.6	20.0	2.4	6.9	12.5	5.0	8.9	0.0
Detox/Methadone maintenance	8.5	10.6	4.2	0.0	6.8	9.5	5.9	7.5	20.0	4.1	0.0	3.8	5.9	22.9	16.7	4.8	3.4	20.0	0.0	10.0	11.1
Medical Case Mgmt	39.0	39.4	37.5	50.0	28.4	52.4	41.2	36.3	60.0	35.7	26.9	38.5	35.3	57.1	53.3	30.1	37.9	40.0	40.0	41.1	11.1
Case management	55.3	58.8	45.8	75.0	40.5	73.0	70.6	47.5	80.0	57.1	50.0	65.4	52.9	71.4	66.7	42.2	56.9	62.5	45.0	61.1	44.4
Employment assistance	10.6	11.8	8.3	0.0	10.8	12.7	11.8	7.5	0.0	11.2	15.4	15.4	2.9	14.3	10.0	8.4	10.3	17.5	7.5	11.1	11.1
Housing Info Srvcs	30.9	32.9	25.0	50.0	27.0	31.7	41.2	30.0	40.0	31.6	34.6	26.9	26.5	40.0	40.0	22.9	27.6	40.0	32.5	32.2	44.4
Rental assistance	21.1	23.5	15.3	25.0	18.9	23.8	23.5	17.5	40.0	18.4	19.2	15.4	17.6	31.4	26.7	18.1	22.4	30.0	17.5	21.1	33.3
Independent housing	41.5	38.8	45.8	75.0	33.8	46.0	70.6	38.8	20.0	43.9	38.5	53.8	41.2	42.9	40.0	38.6	29.3	55.0	42.5	47.8	22.2
Supportive housing	8.5	10.0	5.6	0.0	6.8	14.3	17.6	2.5	20.0	6.1	0.0	11.5	2.9	17.1	16.7	4.8	6.9	22.5	5.0	6.7	11.1
Transitional housing	14.2	17.6	6.9	0.0	12.2	17.5	11.8	10.0	20.0	12.2	19.2	7.7	8.8	22.9	30.0	7.2	15.5	15.0	17.5	14.4	11.1
Food pantry	48.8	48.2	48.6	75.0	41.9	66.7	52.9	41.3	20.0	40.8	34.6	57.7	35.3	80.0	53.3	43.4	43.1	62.5	55.0	51.1	33.3
Food Vouchers	29.7	29.4	27.8	75.0	23.0	28.6	35.3	32.5	60.0	26.5	23.1	19.2	32.4	42.9	36.7	25.3	32.8	30.0	22.5	31.1	11.1
Home delivered meals	21.5	22.4	18.1	50.0	14.9	30.2	29.4	17.5	40.0	20.4	11.5	23.1	26.5	40.0	23.3	14.5	19.0	32.5	12.5	24.4	0.0
Prevention	44.7	42.4	50.0	50.0	43.2	52.4	47.1	36.3	80.0	40.8	38.5	50.0	29.4	60.0	50.0	41.0	50.0	45.0	35.0	48.9	22.2
DEFA	18.3	18.8	15.3	50.0	13.5	22.2	29.4	16.3	20.0	18.4	11.5	23.1	20.6	28.6	16.7	14.5	13.8	30.0	10.0	21.1	11.1
Legal Services	18.3	19.4	15.3	25.0	12.2	28.6	17.6	17.5	0.0	22.4	7.7	38.5	23.5	22.9	13.3	13.3	12.1	22.5	12.5	26.7	11.1
Adult Day Care	3.7	3.5	2.8	25.0	2.7	4.8	5.9	3.8	0.0	2.0	3.8	0.0	2.9	8.6	3.3	3.6	1.7	5.0	0.0	6.7	0.0
Day Care	2.8	1.8	5.6	0.0	1.4	1.6	0.0	5.0	0.0	1.0	0.0	0.0	2.9	2.9	3.3	4.8	0.0	10.0	5.0	1.1	0.0

Attachment 9 Services Received																
	Total								SPECIAL POPULATIONS							
	Sample	SPA2	SPA3	SPA4	SPA5	SPA6	SPA7	SPA8	UNDOC	NON-IDU2	WCB (13-45yo)	REC INC	Severe MH	Current Hmls/ Trans	Hx of Hmls	Hx of Trans
	246	**22**	**21**	**78**	**17**	**51**	**17**	**31**	**18**	**51**	**53**	**41**	**81**	**38**	**48**	**67**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Outpatient Medical Care	68.3	72.7	61.9	74.4	88.2	58.8	52.9	67.7	83.3	66.7	60.4	68.3	76.5	65.8	70.8	74.6
med care w/ specialist	41.9	63.6	38.1	42.3	64.7	39.2	17.6	38.7	50.0	35.3	49.1	31.7	48.1	36.8	41.7	41.8
Nutrition Education	44.3	45.5	52.4	48.7	41.2	27.5	11.8	67.7	27.8	47.1	26.4	51.2	56.8	36.8	45.8	44.8
Dental care	48.8	59.1	57.1	53.8	47.1	39.2	29.4	58.1	44.4	41.2	39.6	48.8	61.7	36.8	52.1	50.7
Home health care	11.8	0.0	9.5	12.8	11.8	17.6	11.8	9.7	5.6	13.7	9.4	4.9	14.8	2.6	6.3	11.9
Hospice	5.7	0.0	14.3	6.4	5.9	3.9	0.0	9.7	5.6	7.8	1.9	2.4	6.2	2.6	4.2	6.0
Complementary care	12.2	22.7	14.3	17.9	0.0	7.8	5.9	9.7	0.0	11.8	5.7	9.8	16.0	18.4	12.5	11.9
Medication Reimbursement	45.9	68.2	47.6	46.2	35.3	25.5	41.2	61.3	61.1	37.3	34.0	48.8	56.8	57.9	54.2	56.7
Health insurance continuation	9.4	9.1	14.3	9.1	5.9	7.8	11.8	9.7	5.6	5.9	9.4	2.4	7.4	2.7	6.4	12.1
Van transportation	24.8	13.6	28.6	25.6	11.8	31.4	29.4	19.4	44.4	27.5	30.2	31.7	35.8	15.8	25.0	29.9
Taxi Vouchers	45.5	50.0	57.1	33.3	58.8	43.1	52.9	51.6	38.9	43.1	52.8	65.9	59.3	42.1	64.6	52.2
Residential mental health srvcs	12.6	31.8	9.5	5.1	23.5	9.8	5.9	19.4	5.6	17.6	0.0	12.2	23.5	21.1	16.7	19.4
Ind. or Grp. Therapy Session	41.5	50.0	38.1	35.9	52.9	31.4	29.4	67.7	27.8	49.0	32.1	53.7	71.6	34.2	56.3	49.3
Peer Counseling	42.0	59.1	33.3	31.2	52.9	37.3	41.2	61.3	38.9	39.2	39.6	43.9	56.8	52.6	56.3	58.2
Outpatient substance counseling	16.7	45.5	19.0	16.7	17.6	5.9	5.9	22.6	5.6	9.8	9.4	39.0	30.9	28.9	37.5	32.8
Residential Substance Counseling	8.1	31.8	14.3	5.1	5.9	3.9	0.0	9.7	0.0	3.9	3.8	14.6	14.8	21.1	18.8	23.9
Detox/Methadone maintenance	8.5	18.2	14.3	7.7	11.8	2.0	5.9	9.7	0.0	2.0	5.7	19.5	16.0	23.7	18.8	19.4
Medical Case Mgmt	39.0	63.6	38.1	33.3	52.9	31.4	35.3	51.6	61.1	41.2	39.6	43.9	54.3	42.1	47.9	43.3
Case management	55.3	72.7	57.1	50.0	70.6	39.2	52.9	77.4	66.7	54.9	47.2	73.2	72.8	68.4	75.0	68.7
Employment assistance	10.6	18.2	14.3	9.0	17.6	5.9	5.9	12.9	5.6	9.8	7.5	17.1	13.6	18.4	18.8	11.9
Housing Info Srvcs	30.9	36.4	33.3	29.5	41.2	23.5	35.3	29.0	33.3	25.5	28.3	46.3	40.7	36.8	50.0	47.8
Rental assistance	21.1	27.3	28.6	17.9	29.4	17.6	23.5	16.1	16.7	19.6	17.0	24.4	30.9	5.3	25.0	22.4
Independent housing	41.5	40.9	23.8	44.9	41.2	37.3	47.1	54.8	44.4	41.2	49.1	41.5	56.8	23.7	41.7	41.8
Supportive housing	8.5	40.9	4.8	3.8	0.0	5.9	0.0	12.9	5.6	5.9	5.7	19.5	13.6	15.8	16.7	16.4
Transitional housing	14.2	18.2	19.0	11.5	29.4	9.8	0.0	22.6	22.2	9.8	7.5	29.3	18.5	28.9	33.3	26.9
Food pantry	48.8	45.5	52.4	52.6	64.7	37.3	47.1	54.8	55.6	47.1	47.2	46.3	66.7	52.6	62.5	58.2
Food Vouchers	29.7	31.8	28.6	29.5	47.1	33.3	11.8	29.0	55.6	29.4	28.3	36.6	45.7	18.4	39.6	32.8
Home delivered meals	21.5	31.8	33.3	21.8	35.3	11.8	11.8	25.8	16.7	27.5	15.1	31.7	35.8	15.8	29.2	19.4
Prevention	44.7	50.0	23.8	41.0	70.6	45.1	23.5	67.7	55.6	45.1	47.2	48.8	55.6	47.4	52.1	46.3
DEFA	18.3	36.4	28.6	20.5	17.6	9.8	11.8	12.9	22.2	15.7	15.1	24.4	29.6	7.9	14.6	13.4
Legal Services	18.3	18.2	9.5	24.4	17.6	13.7	11.8	22.6	22.2	15.7	11.3	17.1	29.6	13.2	18.8	17.9
Adult Day Care	3.7	4.5	4.8	3.8	0.0	2.0	5.9	6.5	5.6	2.0	1.9	2.4	2.5	2.6	4.2	6.0
Day Care	2.8	9.1	4.8	2.6	0.0	3.9	0.0	0.0	11.1	2.0	7.5	4.9	3.7	2.6	2.1	3.0

Attachment 10 2002 Survey - Service Barriers (Mean Rating)

Attachment 10 Barriers (Mean Rating)																				
1 = Very Small	Total	GENDER			ETHNICITY					RISKGRP							STAGE OF INFECTION			
2 = Small 3 = Moderate	Sample	Male	Female	TG	Af Am	Anglo	API	Latino	Native Am	MSM Total	Af Am MSM	Anglo MSM	Latino MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
4 = Big 5 = Very Big	**246**	**170**	**72**	**4**	**74**	**63**	**17**	**80**	**5**	**98**	**26**	**26**	**34**	**35**	**30**	**83**	**58**	**40**	**39**	**90**
Not knowing that a service or tx was available to me	3.2	3.2	3.4	3.3	3.4	3.0	3.2	3.3	2.0	2.9	2.8	2.7	2.9	3.4	3.9	3.2	2.9	3.3	3.4	3.3
Not knowing location	2.9	2.7	3.3	3.7	3.3	2.5	3.0	2.7	2.3	2.6	2.9	2.1	2.4	2.8	3.7	3.0	2.6	2.9	3.1	2.9
Physical health	2.6	2.5	3.0	3.3	2.7	2.4	3.3	2.6	2.3	2.5	2.2	2.4	2.4	2.5	3.1	2.8	2.4	2.7	2.4	2.8
Denial	2.9	2.8	3.1	5.0	3.1	2.8	3.2	2.8	2.0	2.7	2.6	2.5	2.3	3.1	3.0	3.0	3.0	3.1	2.9	2.9
Not knowing what services I need to treat HIV/AIDS	2.8	2.9	2.7	2.5	2.9	2.7	2.3	2.9	1.7	2.8	2.6	2.9	2.7	2.9	3.4	2.6	2.8	3.0	2.6	2.9
State of mind	2.8	2.8	2.6	4.5	3.0	2.7	2.5	2.7	2.3	2.9	3.0	2.3	2.9	2.7	3.7	2.3	3.0	3.0	2.6	2.7
Not understanding instructions	2.6	2.7	2.4	3.5	2.7	2.5	3.1	2.5	2.0	2.8	2.5	2.4	2.8	2.3	2.9	2.5	2.3	2.5	2.9	2.7
Not knowing who to ask for help	2.9	2.9	2.9	2.0	3.4	2.7	3.0	2.6	3.0	2.9	3.3	2.5	2.6	2.9	3.5	2.6	2.6	3.2	2.9	3.0
Sensitivity of org to my issues	2.9	2.9	3.1	3.3	3.1	3.0	2.9	2.9	2.0	2.7	2.7	2.5	2.8	3.2	3.1	3.0	2.6	3.4	2.4	3.0
Discrimination	2.6	2.6	2.6	3.3	2.8	2.1	3.0	2.8	2.0	2.8	2.4	2.0	3.0	2.2	2.9	2.6	2.4	2.7	2.4	2.7
Experience or expertise of provider	2.9	2.8	3.0	2.7	3.2	2.6	2.8	2.7	2.4	2.8	2.5	2.6	2.9	2.9	3.1	2.9	2.8	3.0	2.8	2.9
Wait time for appt	3.0	2.8	3.3	3.0	3.1	2.9	3.3	2.8	1.8	2.8	2.6	2.6	2.8	3.0	3.5	3.0	2.9	3.3	3.1	2.9
Made to feel like a number	3.0	3.0	3.2	2.3	3.1	3.0	2.6	3.0	2.0	2.9	2.5	2.9	3.0	3.5	2.9	2.9	2.9	3.1	2.7	3.2
Do not get along with providers	2.3	2.2	2.5	2.0	2.5	1.9	2.0	2.4	2.3	2.1	2.1	2.0	2.1	2.1	2.7	2.4	2.2	2.7	1.9	2.2
Eligibility due to criminal justice matter	2.4	2.4	2.4	2.5	2.4	2.5	5.0	2.6	1.5	2.6	2.4	1.7	3.1	2.2	2.6	2.2	2.1	2.4	2.2	2.3
Communication w provider	2.3	2.3	2.2	2.3	2.2	2.6	3.1	1.9	1.5	2.1	1.6	2.2	2.2	2.5	2.7	2.2	2.1	2.3	2.1	2.5
Provider expertise	2.4	2.4	2.4	2.0	2.5	2.3	2.9	2.2	2.0	2.3	2.2	1.8	2.3	2.8	2.9	2.0	2.5	1.9	2.3	2.5
Provider gave poor referrals	2.5	2.5	2.7	2.5	2.8	2.3	2.8	2.5	1.5	2.4	2.3	2.3	2.3	2.6	3.3	2.4	2.2	2.3	2.8	2.7
Navigate system	2.8	2.8	2.7	2.3	3.2	2.7	3.0	2.3	2.7	2.4	2.8	2.3	2.0	3.1	3.3	2.7	2.4	2.8	3.1	2.8
Lack of specialists	2.5	2.4	2.7	1.0	2.7	2.5	4.0	2.1	2.0	2.4	2.3	2.3	2.1	2.5	2.9	2.4	2.3	2.5	2.9	2.2
Lack of confidentiality	3.1	2.9	3.3	5.0	3.6	2.5	3.2	2.9	3.7	2.9	3.3	1.9	2.9	2.9	3.4	3.3	3.1	2.8	2.9	3.2
Fear of being reported to authorities	2.2	2.2	2.2	1.0	1.9	1.8	3.7	2.8	1.0	2.4	1.6	2.0	3.5	1.4	2.8	2.2	2.2	2.8	2.2	1.8
No transportation	3.2	3.1	3.4	3.0	3.0	3.2	3.9	3.2	2.7	3.1	2.8	3.2	3.0	2.6	3.8	3.2	3.2	3.0	2.9	3.5
No childcare	2.9	2.3	3.4	1.0	2.7	2.1	3.0	3.4	1.0	2.6	2.3	2.0	3.8	1.3	3.7	3.0	2.4	2.8	3.0	2.6
Not eligible	2.9	2.8	3.3	1.0	3.0	2.6	4.2	2.8	2.0	2.8	2.9	2.1	2.6	2.8	3.5	2.9	3.1	2.8	3.2	2.8
Red tape	2.9	2.8	3.1	2.5	3.0	2.7	4.1	2.7	1.7	2.6	2.5	2.1	2.6	3.0	3.8	2.9	3.1	3.0	3.1	2.8
Cannot afford service	2.9	3.0	3.0	1.0	3.3	2.7	3.9	2.8	1.0	2.9	3.0	2.5	2.5	3.0	3.6	2.8	3.1	2.9	2.6	3.0
Rules and regulations	2.9	2.7	3.3	1.0	2.9	2.3	3.9	2.9	1.0	2.6	2.5	2.0	2.6	3.0	3.5	2.9	3.2	2.6	3.1	2.7
Lack of insurance coverage	2.9	2.9	2.9	1.5	3.1	2.9	3.8	2.7	2.0	2.7	2.9	2.5	2.2	3.0	3.3	2.9	2.9	2.8	3.0	2.8
Terminated/suspended from srvc(s)	2.5	2.3	2.7	3.0	2.5	2.3	3.4	2.7	1.0	2.5	2.4	1.0	2.8	2.2	2.9	2.5	2.3	2.5	2.5	2.6
TOTAL AVG	**2.7**	**2.7**	**2.9**	**2.6**	**2.9**	**2.6**	**3.3**	**2.7**	**1.9**	**2.6**	**2.5**	**2.3**	**2.7**	**2.7**	**3.2**	**2.7**	**2.7**	**2.8**	**2.7**	**2.8**

Attachment 10 Barriers (Mean Rating)																	
1 = Very Small	Total	Location								SPECIAL POPULATIONS							
2 = Small 3 = Moderate	Sample	SPA1	SPA2	SPA3	SPA4	SPA5	SPA6	SPA7	SPA8	UNDOC	NON-IDU2	WCB (13-45yo)	REC INC	Severe MH	Current Hmls/ Trans	Hx of Hmls	Hx of Trans
4 = Big 5 = Very Big	**246**	**9**	**22**	**21**	**78**	**17**	**51**	**17**	**31**	**18**	**51**	**53**	**41**	**81**	**38**	**48**	**67**
Not knowing that a service or tx was available to me	3.2	4.0	2.8	3.5	3.2	3.0	3.4	2.7	3.2	3.2	3.1	3.5	3.4	3.3	3.3	3.5	3.3
Not knowing location	2.9	3.3	2.4	3.0	2.6	2.9	3.3	2.0	3.2	2.7	2.6	3.4	2.9	2.7	2.6	2.8	2.9
Physical health	2.6	2.5	2.3	3.2	2.8	2.4	2.7	2.5	2.6	3.1	2.4	3.0	2.7	2.5	2.2	2.3	2.5
Denial	2.9	2.0	2.8	3.0	2.8	2.8	3.3	2.7	2.8	3.3	2.7	3.3	2.8	3.1	2.9	3.0	2.9
Not knowing what services I need to treat HIV/AIDS	2.8	2.0	2.8	2.8	3.0	2.6	2.8	3.0	2.6	3.6	2.6	2.6	3.0	2.9	2.8	3.0	2.9
State of mind	2.8	2.3	3.1	2.5	2.5	3.1	2.5	3.0	3.3	2.9	2.8	2.6	3.1	3.0	3.1	3.5	2.9
Not understanding instructions	2.6	2.3	2.1	3.3	2.8	2.1	2.6	3.0	2.6	3.0	2.7	2.3	2.6	2.6	2.1	2.6	2.4
Not knowing who to ask for help	2.9	4.2	3.2	3.0	2.7	2.3	2.8	3.0	3.0	3.0	2.8	3.1	3.2	2.8	2.9	3.2	2.9
Sensitivity of org to my issues	2.9	4.3	2.5	3.6	3.1	2.8	2.8	2.5	2.9	2.8	2.9	2.9	3.0	2.8	2.9	3.0	2.6
Discrimination	2.6	4.8	2.1	3.6	2.5	2.4	2.4	3.3	2.7	3.1	2.5	2.4	2.6	2.4	2.3	2.7	2.7
Experience or expertise of provider	2.9	4.3	2.5	2.7	3.0	2.9	2.8	2.5	3.0	2.6	2.8	2.9	3.1	2.9	2.5	3.0	2.7
Wait time for appt	3.0	4.0	3.1	2.4	3.0	2.9	2.8	2.3	3.1	3.3	2.9	3.2	3.0	2.7	3.0	3.0	2.8
Made to feel like a number	3.0	4.8	2.7	3.1	3.0	3.0	2.8	3.0	2.9	3.0	3.1	3.3	3.2	2.8	2.8	3.1	3.0
Do not get along with providers	2.3	3.3	2.3	3.0	2.0	2.1	2.2	2.0	2.4	2.0	2.2	2.4	2.3	2.2	2.2	2.2	2.1
Eligibility due to criminal justice matter	2.4	1.0	2.6	3.3	2.8	2.4	1.9	2.8	2.0	2.2	2.5	2.6	2.6	2.3	2.7	2.5	2.6
Communication w provider	2.3	1.0	2.6	2.4	2.4	2.0	2.1	2.2	2.3	2.1	2.0	2.3	2.2	2.3	2.0	2.2	2.0
Provider expertise	2.4	2.0	2.5	2.3	2.2	2.5	2.3	2.2	2.9	1.6	2.3	2.5	2.3	2.4	2.6	2.4	2.4
Provider gave poor referrals	2.5	2.3	2.4	2.7	2.5	2.3	2.8	2.2	2.8	2.1	2.5	2.8	2.2	2.5	2.7	2.5	2.5
Navigate system	2.8	3.3	2.6	2.4	2.5	3.3	2.8	3.0	2.8	2.2	2.6	2.5	2.6	2.7	3.2	3.1	2.7
Lack of specialists	2.5	3.0	2.1	2.4	2.6	2.1	2.4	2.6	2.8	2.0	2.3	2.6	2.2	2.4	2.6	2.5	2.3
Lack of confidentiality	3.1	3.7	2.8	3.3	2.7	3.6	3.5	3.2	2.9	2.6	3.1	3.4	3.3	2.8	3.2	3.2	3.2
Fear of being reported to authorities	2.2	1.0	2.3	2.5	2.4	1.7	2.5	2.5	1.7	2.8	2.6	2.3	2.1	2.1	1.8	1.8	1.9
No transportation	3.2	3.4	3.0	3.5	3.1	3.2	3.5	2.9	3.0	2.7	3.1	3.5	3.2	3.1	3.2	3.3	3.1
No childcare	2.9	2.0	2.3	2.0	2.8	1.8	3.3	3.6	3.2	3.1	3.0	3.6	2.8	2.7	2.3	3.1	2.4
Not eligible	2.9	3.7	2.8	1.8	2.8	3.1	2.9	2.5	3.2	2.6	2.8	3.4	3.2	2.8	3.2	3.3	2.6
Red tape	2.9	4.1	2.8	2.3	2.7	3.1	2.7	2.3	3.6	2.6	2.6	3.1	3.4	2.8	3.2	3.2	2.6
Cannot afford service	2.9	2.3	2.8	2.1	3.0	3.1	3.1	2.2	3.4	2.7	3.4	3.1	3.1	2.8	3.2	3.1	2.6
Rules and regulations	2.9	4.0	2.5	2.5	2.7	3.1	2.9	2.2	3.3	2.7	2.5	3.4	2.9	2.6	2.6	3.0	2.5
Lack of insurance coverage	2.9	1.5	3.2	1.8	3.1	3.2	2.4	3.3	3.2	2.4	2.9	3.1	2.5	2.8	3.2	3.2	3.0
Terminated/suspended from srvc(s)	2.5	1.5	2.6	1.7	2.8	2.3	2.6	3.0	2.4	2.3	3.1	2.8	2.1	2.1	2.3	2.2	1.8
TOTAL AVG	**2.7**	**2.9**	**2.6**	**2.7**	**2.7**	**2.7**	**2.8**	**2.7**	**2.9**	**2.7**	**2.7**	**2.9**	**2.8**	**2.7**	**2.7**	**2.9**	**2.6**

Attachment 11 2002 Survey - Service Barriers (% with Problems)

Attachment 11 Service Barriers (% with Problems)																				
	Total	GENDER			ETHNICITY					RISKGRP							STAGE OF INFECTION			
	Sample	Male	Female	TG	Af Am	Anglo	API	Latino	Native Am	MSM Total	Af Am MSM	Anglo MSM	Latino MSM	MSM/ IDU	IDU	Het	HIV asymp	HIV symp	AIDS asymp	AIDS symp
	246	**170**	**72**	**4**	**74**	**63**	**17**	**80**	**5**	**98**	**26**	**26**	**34**	**35**	**30**	**83**	**58**	**40**	**39**	**90**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Not knowing that a service or tx was available to me	72.4	73.5	69.4	75.0	77.0	73.0	70.6	67.5	80.0	69.4	80.8	61.5	64.7	88.6	70.0	69.9	63.8	72.5	62.5	80.0
Not knowing location	66.7	64.1	72.2	75.0	75.7	54.0	76.5	65.0	80.0	62.2	76.9	38.5	64.7	68.6	70.0	69.9	56.9	72.5	52.5	73.3
Physical health	60.2	57.1	66.7	75.0	71.6	47.6	58.8	61.3	60.0	56.1	65.4	42.3	58.8	65.7	56.7	63.9	46.6	67.5	50.0	66.7
Denial	67.5	63.5	77.8	50.0	77.0	54.0	76.5	67.5	60.0	62.2	76.9	42.3	64.7	65.7	66.7	74.7	60.3	77.5	65.0	66.7
Not knowing what services I need to treat HIV/AIDS	59.8	57.1	65.3	75.0	75.7	41.3	64.7	58.8	60.0	56.1	73.1	42.3	52.9	60.0	56.7	65.1	50.0	57.5	62.5	61.1
State of mind	64.6	63.5	66.7	75.0	77.0	46.0	70.6	63.8	60.0	60.2	76.9	30.8	67.6	74.3	66.7	65.1	50.0	70.0	57.5	71.1
Not understanding instructions	57.7	56.5	59.7	75.0	71.6	41.3	52.9	58.8	60.0	52.0	69.2	26.9	58.8	65.7	66.7	57.8	46.6	65.0	55.0	58.9
Not knowing who to ask for help	64.6	62.9	66.7	100.0	73.0	50.8	76.5	62.5	80.0	63.3	73.1	42.3	64.7	65.7	66.7	65.1	58.6	70.0	60.0	65.6
Sensitivity of org to my issues	64.2	61.8	68.1	100.0	74.3	49.2	70.6	63.8	80.0	67.3	73.1	46.2	73.5	65.7	60.0	61.4	56.9	62.5	57.5	71.1
Discrimination	56.5	52.9	62.5	100.0	67.6	44.4	47.1	55.0	40.0	59.2	69.2	38.5	67.6	57.1	53.3	54.2	43.1	60.0	60.0	62.2
Experience or expertise of provider	63.8	64.1	61.1	100.0	70.3	63.5	58.8	56.3	100.0	66.3	73.1	57.7	64.7	74.3	63.3	56.6	53.4	65.0	62.5	70.0
Wait time for appt	67.5	67.6	66.7	75.0	73.0	65.1	70.6	61.3	80.0	74.5	76.9	73.1	70.6	65.7	56.7	63.9	53.4	70.0	70.0	73.3
Made to feel like a number	61.8	61.8	59.7	100.0	74.3	55.6	58.8	53.8	60.0	68.4	80.8	61.5	61.8	54.3	66.7	55.4	55.2	62.5	72.5	62.2
Do not get along with providers	50.0	49.4	50.0	75.0	64.9	42.9	17.6	46.3	60.0	52.0	69.2	42.3	50.0	51.4	56.7	44.6	37.9	55.0	60.0	50.0
Eligibility due to criminal justice matter	40.2	40.0	38.9	75.0	56.8	23.8	11.8	43.8	40.0	35.7	53.8	11.5	44.1	48.6	43.3	41.0	31.0	52.5	30.0	42.2
Communication w provider	48.0	45.3	51.4	100.0	52.7	34.9	47.1	53.8	40.0	46.9	46.2	34.6	55.9	54.3	40.0	49.4	34.5	52.5	47.5	52.2
Provider expertise	53.7	51.8	55.6	100.0	59.5	46.0	41.2	56.3	20.0	57.1	61.5	46.2	61.8	51.4	50.0	51.8	36.2	57.5	50.0	64.4
Provider gave poor referrals	56.9	55.9	58.3	75.0	63.5	47.6	41.2	60.0	40.0	57.1	57.7	46.2	64.7	65.7	50.0	55.4	44.8	60.0	55.0	62.2
Navigate system	62.2	60.6	63.9	100.0	68.9	55.6	70.6	58.8	60.0	60.2	65.4	46.2	64.7	74.3	60.0	60.2	53.4	72.5	50.0	65.6
Lack of specialists	52.4	51.2	55.6	50.0	54.1	46.0	47.1	58.8	20.0	55.1	53.8	46.2	61.8	57.1	40.0	51.8	39.7	65.0	50.0	55.6
Lack of confidentiality	52.0	50.0	55.6	75.0	63.5	31.7	64.7	52.5	60.0	51.0	57.7	30.8	55.9	48.6	50.0	55.4	39.7	57.5	52.5	54.4
Fear of being reported to authorities	30.5	26.5	38.9	50.0	37.8	17.5	23.5	35.0	20.0	27.6	30.8	15.4	32.4	25.7	23.3	38.6	22.4	30.0	35.0	32.2
No transportation	58.9	57.1	62.5	75.0	66.2	46.0	52.9	60.0	60.0	55.1	73.1	34.6	52.9	60.0	60.0	62.7	55.2	65.0	55.0	61.1
No childcare	37.0	29.4	54.2	50.0	45.9	14.3	29.4	47.5	20.0	31.6	38.5	11.5	41.2	20.0	33.3	51.8	31.0	42.5	30.0	37.8
Not eligible	56.9	53.5	63.9	75.0	60.8	54.0	41.2	57.5	60.0	56.1	69.2	42.3	55.9	60.0	53.3	57.8	53.4	60.0	45.0	61.1
Red tape	61.4	59.4	65.3	75.0	64.9	57.1	52.9	62.5	60.0	62.2	57.7	53.8	67.6	60.0	56.7	62.7	50.0	67.5	57.5	64.4
Cannot afford service	53.3	51.2	58.3	50.0	59.5	34.9	47.1	62.5	40.0	54.1	69.2	30.8	61.8	48.6	46.7	56.6	44.8	50.0	47.5	60.0
Rules and regulations	56.5	55.9	58.3	50.0	59.5	44.4	64.7	62.5	40.0	59.2	65.4	46.2	64.7	60.0	50.0	54.2	43.1	55.0	52.5	65.6
Lack of insurance coverage	57.7	55.3	62.5	75.0	66.2	42.9	52.9	61.3	60.0	57.1	69.2	38.5	61.8	62.9	50.0	59.0	62.1	57.5	52.5	54.4
Terminated/suspended from srvc(s)	36.2	32.4	43.1	75.0	51.4	15.9	35.3	38.8	20.0	31.6	42.3	7.7	38.2	37.1	30.0	43.4	27.6	35.0	32.5	40.0

Attachment 11 Service Barriers (% with Problems)																	
	Total	Location								SPECIAL POPULATIONS							
	Sample	SPA1	SPA2	SPA3	SPA4	SPA5	SPA6	SPA7	SPA8	UNDOC	NON-IDU2	WCB (13-45yo)	REC INC	Severe MH	Current Hmls/ Trans	Hx of Hmls	Hx of Trans
	246	**9**	**22**	**21**	**78**	**17**	**51**	**17**	**31**	**18**	**51**	**53**	**41**	**81**	**38**	**48**	**67**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Not knowing that a service or tx was available to me	72.4	77.8	68.2	81.0	71.8	70.6	82.4	41.2	71.0	72.2	74.5	69.8	87.8	77.8	71.1	79.2	79.1
Not knowing location	66.7	77.8	59.1	76.2	59.0	70.6	78.4	52.9	67.7	72.2	68.6	73.6	80.5	71.6	63.2	75.0	76.1
Physical health	60.2	55.6	68.2	57.1	55.1	64.7	72.5	58.8	48.4	61.1	58.8	67.9	68.3	64.2	55.3	64.6	64.2
Denial	67.5	44.4	68.2	66.7	57.7	82.4	82.4	58.8	71.0	72.2	58.8	81.1	75.6	60.5	65.8	81.3	76.1
Not knowing what services I need to treat HIV/AIDS	59.8	44.4	63.6	57.1	50.0	76.5	74.5	47.1	61.3	61.1	56.9	69.8	70.7	55.6	52.6	70.8	68.7
State of mind	64.6	55.6	68.2	61.9	55.1	64.7	76.5	58.8	74.2	61.1	56.9	64.2	80.5	72.8	52.6	77.1	70.1
Not understanding instructions	57.7	55.6	54.5	52.4	52.6	64.7	72.5	52.9	51.6	55.6	49.0	58.5	68.3	59.3	50.0	72.9	64.2
Not knowing who to ask for help	64.6	66.7	59.1	52.4	60.3	70.6	78.4	41.2	74.2	66.7	74.5	67.9	82.9	67.9	57.9	79.2	70.1
Sensitivity of org to my issues	64.2	55.6	72.7	42.9	60.3	64.7	78.4	47.1	71.0	61.1	66.7	69.8	75.6	70.4	55.3	75.0	70.1
Discrimination	56.5	55.6	68.2	42.9	48.7	58.8	68.6	35.3	67.7	50.0	60.8	62.3	68.3	59.3	42.1	64.6	62.7
Experience or expertise of provider	63.8	55.6	72.7	57.1	59.0	70.6	72.5	47.1	67.7	44.4	68.6	60.4	73.2	69.1	47.4	70.8	68.7
Wait time for appt	67.5	55.6	77.3	66.7	65.4	76.5	66.7	47.1	77.4	61.1	76.5	66.0	85.4	71.6	63.2	75.0	71.6
Made to feel like a number	61.8	55.6	63.6	52.4	61.5	70.6	70.6	41.2	61.3	55.6	68.6	56.6	75.6	61.7	57.9	68.8	67.2
Do not get along with providers	50.0	55.6	50.0	38.1	47.4	58.8	62.7	35.3	45.2	44.4	49.0	47.2	68.3	56.8	44.7	58.3	59.7
Eligibility due to criminal justice matter	40.2	33.3	54.5	33.3	35.9	47.1	43.1	35.3	41.9	38.9	29.4	43.4	56.1	44.4	39.5	50.0	49.3
Communication w provider	48.0	33.3	45.5	47.6	46.2	58.8	56.9	41.2	41.9	61.1	39.2	56.6	58.5	53.1	34.2	58.3	55.2
Provider expertise	53.7	55.6	50.0	47.6	56.4	58.8	54.9	41.2	54.8	61.1	49.0	58.5	61.0	58.0	47.4	66.7	61.2
Provider gave poor referrals	56.9	55.6	63.6	47.6	55.1	70.6	58.8	47.1	58.1	66.7	51.0	60.4	56.1	61.7	50.0	60.4	65.7
Navigate system	62.2	55.6	63.6	57.1	66.7	70.6	62.7	41.2	61.3	55.6	60.8	64.2	73.2	67.9	63.2	72.9	70.1
Lack of specialists	52.4	44.4	59.1	47.6	52.6	64.7	51.0	41.2	54.8	61.1	47.1	54.7	48.8	53.1	44.7	54.2	55.2
Lack of confidentiality	52.0	44.4	54.5	42.9	52.6	58.8	56.9	41.2	51.6	50.0	43.1	56.6	58.5	56.8	42.1	56.3	53.7
Fear of being reported to authorities	30.5	33.3	40.9	28.6	32.1	35.3	37.3	23.5	9.7	50.0	19.6	41.5	34.1	25.9	23.7	33.3	34.3
No transportation	58.9	66.7	63.6	52.4	52.6	76.5	58.8	58.8	64.5	72.2	64.7	64.2	78.0	55.6	60.5	72.9	68.7
No childcare	37.0	44.4	36.4	38.1	33.3	35.3	43.1	41.2	32.3	61.1	25.5	58.5	34.1	24.7	21.1	35.4	40.3
Not eligible	56.9	55.6	59.1	47.6	55.1	70.6	60.8	35.3	64.5	77.8	51.0	66.0	58.5	54.3	60.5	75.0	65.7
Red tape	61.4	88.9	59.1	61.9	60.3	76.5	60.8	47.1	58.1	72.2	58.8	67.9	65.9	65.4	55.3	75.0	62.7
Cannot afford service	53.3	55.6	54.5	57.1	44.9	82.4	60.8	41.2	48.4	61.1	49.0	62.3	53.7	55.6	47.4	64.6	59.7
Rules and regulations	56.5	55.6	59.1	61.9	55.1	70.6	56.9	47.1	51.6	66.7	45.1	58.5	61.0	59.3	57.9	64.6	62.7
Lack of insurance coverage	57.7	44.4	59.1	66.7	53.8	76.5	62.7	35.3	58.1	72.2	54.9	67.9	68.3	54.3	60.5	68.8	74.6
Terminated/suspended from srvc(s)	36.2	44.4	36.4	38.1	30.8	52.9	43.1	23.5	32.3	44.4	21.6	45.3	39.0	32.1	31.6	39.6	43.3

Attachment 12 Special Population Comparative Data Table

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
SPA (OAPP Client Database)													
Antelope Valley	1.5	1.6	1.7	0.7	2.4	0.9	- -	- -	2.5	0.6	1.9	- -	- -
San Fernando	11.5	5.4	14.3	11.2	12.4	11.8	- -	- -	11.3	11.6	11.1	- -	- -
San Gabriel	7.1	5.9	5.5	8.9	10.4	6.1	- -	- -	9.3	1.7	8.3	- -	- -
Metro	37.9	29.7	46.7	43.9	21.8	36.2	- -	- -	22.5	49.1	19.9	- -	- -
West	4.3	3.8	7.6	3.2	3.3	3.8	- -	- -	3.8	1.7	2.8	- -	- -
South	15.5	31.8	1.3	9.0	13.3	14.5	- -	- -	26.1	14.5	26.4	- -	- -
East	6.3	1.6	2.0	11.0	5.8	5.0	- -	- -	8.1	2.3	6.0	- -	- -
South Bay - LB	15.9	20.1	20.8	12.2	30.5	21.6	- -	- -	16.5	18.5	23.6	- -	- -
SPA (APLA)													
Antelope Valley	0.8	2.3	0.5	0.6	- -	0.0	0.9	1.5	1.9	0.0	0.0	- -	- -
San Fernando	14.9	8.5	20.1	10.0	- -	6.7	15.2	15.2	12.3	12.5	18.2	- -	- -
San Gabriel	2.0	0.8	2.0	3.0	- -	1.3	2.3	2.5	1.9	0.0	9.1	- -	- -
Metro	58.6	44.2	64.3	65.0	- -	66.7	57.9	54.8	35.8	75.0	54.5	- -	- -
West	5.9	5.4	5.6	5.2	- -	4.0	5.7	5.0	12.3	0.0	9.1	- -	- -
South	9.1	31.8	0.5	7.3	- -	18.7	9.1	11.5	23.6	8.3	9.1	- -	- -
East	2.6	0.0	0.9	5.2	- -	1.3	2.7	3.1	2.8	0.0	0.0	- -	- -
South Bay - LB	6.2	7.0	6.0	3.6	- -	1.3	6.3	6.5	9.4	4.2	0.0	- -	- -
SPA (SHAS)													
Antelope Valley	0.5	1.4	2.0	0.0	1.0	0.0	0.0	0.0	- -	- -	- -	- -	- -
San Fernando	11.1	2.9	31.4	11.3	11.5	11.8	15.4	12.1	- -	- -	- -	- -	- -
San Gabriel	10.9	5.7	3.9	12.8	13.5	7.8	12.0	14.1	- -	- -	- -	- -	- -
Metro	31.3	20.0	43.1	35.5	33.7	49.0	31.5	29.3	- -	- -	- -	- -	- -
West	2.0	0.0	7.8	0.0	3.8	0.0	2.5	2.5	- -	- -	- -	- -	- -
South	24.6	45.7	0.0	17.0	20.2	21.6	21.6	27.3	- -	- -	- -	- -	- -
East	9.4	1.4	3.9	15.6	6.7	2.0	7.9	6.1	- -	- -	- -	- -	- -
South Bay - LB	6.4	18.6	0.0	4.3	5.8	2.0	6.6	5.6	- -	- -	- -	- -	- -
Unknown	3.5	4.3	7.8	3.5	3.8	5.9	2.5	2.0	- -	- -	- -	- -	- -
Serostatus (2002 Survey)													
HIV+ with disabling symptoms	57.0	53.3	59.6	72.7	53.2	55.3	50.0	57.5	53.0	75.0	- -	43.8	68.5
HIV+ with no symptoms	43.0	46.7	40.4	27.3	46.8	44.7	50.0	42.5	47.0	25.0	- -	56.3	31.5
Current HIV Status (APLA)													
HIV+, asymptomatic	34.4	40.5	34.3	39.0	- -	23.3	33.6	32.5	31.0	36.4	72.7	- -	- -
HIV+, symptomatic	29.5	28.2	24.0	34.9	- -	39.7	29.2	32.5	31.0	50.0	27.3	- -	- -
AIDS diagnosis	36.1	31.3	41.7	26.0	- -	37.0	37.1	35.0	38.0	13.6	0.0	- -	- -
AGE (mean value) (2002 Survey)	42.7	45.1	46.0	41.1	42.6	40.2	41.5	40.8	38.9	38.1	- -	35.0	43.6
AGEGROUP (OAPP Client Database)													
< 13	5.3	0.0	0.0	0.1	0.0	3.3	- -	- -	0.0	4.7	0.8	- -	- -
13-19	1.3	0.7	0.1	0.4	0.1	1.1	- -	- -	3.7	4.7	99.2	- -	- -
20-24	2.5	1.9	0.9	4.1	2.1	2.9	- -	- -	5.1	7.9	0.0	- -	- -
25-54	84.5	92.9	90.3	91.9	93.2	89.3	- -	- -	87.0	82.7	0.0	- -	- -
55+	6.4	4.5	8.7	3.6	4.6	3.3	- -	- -	4.2	0.0	0.0	- -	- -
AGEGROUP (2002 Survey)													
13-19	1.3	0.0	0.0	2.8	0.0	0.0	2.1	0.0	3.0	0.0	- -	5.6	0.0
20-24	1.7	0.0	2.1	0.0	1.6	2.1	2.1	2.4	4.5	0.0	- -	0.0	1.3
25-54	87.2	89.7	80.9	91.7	93.8	95.8	89.4	95.1	85.1	100.0	- -	94.4	90.9
55+	9.8	10.3	17.0	5.6	4.7	2.1	6.4	2.4	7.5	0.0	- -	0.0	7.8
AGEGROUP (Transgender)													
18-29	- -	- -	- -	- -	- -	- -	- -	- -	- -	33.3	- -	- -	- -
30-39	- -	- -	- -	- -	- -	- -	- -	- -	- -	63.0	- -	- -	- -
>= 40	- -	- -	- -	- -	- -	- -	- -	- -	- -	3.7	- -	- -	- -

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
AGEGROUP (APLA)													
13-24	1.4	1.5	0.2	2.7	- -	2.6	1.5	1.2	4.7	0.0	100.0	- -	- -
25 - 29	4.1	0.0	1.4	9.6	- -	7.9	4.1	3.6	9.3	0.0	0.0	- -	- -
30-39	33.0	34.3	28.2	43.5	- -	57.9	33.2	36.8	31.8	44.0	0.0	- -	- -
40-49	40.0	51.1	44.9	30.0	- -	26.3	39.7	39.8	31.8	40.0	0.0	- -	- -
50 - 59	15.5	8.8	19.2	9.9	- -	2.6	15.4	13.4	19.6	8.0	0.0	- -	- -
60+	6.0	4.4	6.1	4.2	- -	2.6	6.0	5.2	2.8	8.0	0.0	- -	- -
AGEGROUP (LAC-USC 5P21)													
13-24	- -	0.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
25 - 29	- -	2.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
30-39	- -	46.0	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
40-49	- -	45.2	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
50 - 59	- -	5.2	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Gender (OAPP Client Database)													
Male	79.0	98.3	99.7	98.3	76.7	78.5	- -	- -	0.0	0.0	51.2	- -	- -
Female	19.1	0.0	0.0	0.0	21.5	19.6	- -	- -	100.0	0.0	45.1	- -	- -
Transgender	1.0	1.7	0.2	1.5	1.7	1.8	- -	- -	0.0	100.0	3.7	- -	- -
Gender (2002 Survey)													
Male	69.1	96.8	100.0	94.6	86.2	72.9	76.5	85.4	0.0	0.0	- -	50.0	76.5
Female	29.3	0.0	0.0	0.0	12.3	25.0	19.6	12.2	100.0	0.0	- -	38.9	21.0
Transgender - MTF	1.2	3.2	0.0	5.4	0.0	2.1	3.9	2.4	0.0	75.0	- -	11.1	1.2
Transgender - FTM	0.4	0.0	0.0	0.0	1.5	0.0	0.0	0.0	0.0	25.0	- -	0.0	1.2
Gender (APLA)													
Male	89.7	98.5	99.8	97.0	- -	78.9	90.5	89.4	0.0	0.0	72.7	- -	- -
Female	7.9	0.0	0.0	0.0	- -	15.8	7.9	7.9	100.0	0.0	27.3	- -	- -
transgender (M to F)	1.8	1.5	0.2	3.0	- -	5.3	1.5	2.7	0.0	100.0	0.0	- -	- -
Are you a transgender person (LAC-USC 5P21)	- -	5.6	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Ethnicity (OAPP Client Database)													
Af Am	25.1	100.0	0.0	0.0	32.6	39.1	- -	- -	36.2	34.8	40.0	- -	- -
Anglo	29.3	0.0	100.0	0.0	38.7	29.9	- -	- -	16.0	9.8	10.0	- -	- -
API	1.9	0.0	0.0	0.0	1.2	0.9	- -	- -	1.7	4.9	2.6	- -	- -
Latino	39.3	0.0	0.0	100.0	23.7	26.7	- -	- -	41.8	47.6	45.2	- -	- -
Nat Am	0.5	0.0	0.0	0.0	1.0	0.8	- -	- -	0.6	1.8	1.3	- -	- -
Other/Unknown	3.9	0.0	0.0	0.0	2.9	2.5	- -	- -	3.7	1.2	0.9	- -	- -
Ethnicity (2002 Survey)													
African American (Black)	30.2	100.0	0.0	0.0	18.8	31.3	41.2	31.7	44.4	50.0	- -	0.0	27.5
White / Caucasian (non Hispanic)	25.7	0.0	100.0	0.0	51.6	29.2	17.6	31.7	9.7	0.0	- -	0.0	35.0
Asian / Pacific Islander (API)	6.9	0.0	0.0	0.0	3.1	0.0	5.9	0.0	5.6	0.0	- -	5.6	5.0
Latino / Hispanic	32.7	0.0	0.0	100.0	17.2	31.3	29.4	24.4	38.9	50.0	- -	94.4	27.5
Native American	2.0	0.0	0.0	0.0	4.7	2.1	3.9	4.9	0.0	0.0	- -	0.0	1.3
Mixed Race	1.6	0.0	0.0	0.0	4.7	4.2	0.0	4.9	1.4	0.0	- -	0.0	2.5
Other	0.8	0.0	0.0	0.0	0.0	2.1	2.0	2.4	0.0	0.0	- -	0.0	1.3
Ethnicity (APLA)													
African American (Black)	14.7	100.0	0.0	0.0	- -	27.0	14.3	25.0	27.4	12.5	18.2	- -	- -
White / Caucasian (non Hispanic)	45.7	0.0	100.0	0.0	- -	35.1	45.8	42.0	29.2	4.2	27.3	- -	- -
Asian / Pacific Islander (API)	2.2	0.0	0.0	0.0	- -	0.0	2.4	0.6	1.9	4.2	0.0	- -	- -
Latino / Hispanic	31.8	0.0	0.0	100.0	- -	29.7	32.3	25.9	33.0	66.7	54.5	- -	- -
American Indian	1.1	0.0	0.0	0.0	- -	4.1	0.9	1.9	2.8	4.2	0.0	- -	- -
Other/Mixed	4.6	0.0	0.0	0.0	- -	4.1	4.3	4.6	5.7	8.3	0.0	- -	- -

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Race / Ethnicity (Transgender)													
African American (Black)	- -	- -	- -	- -	- -	- -	- -	- -	- -	11.5	- -	- -	- -
Asian / Pacific Islander (API)	- -	- -	- -	- -	- -	- -	- -	- -	- -	3.8	- -	- -	- -
White / Caucasian (non Hispanic)	- -	- -	- -	- -	- -	- -	- -	- -	- -	11.5	- -	- -	- -
Latino / Hispanic	- -	- -	- -	- -	- -	- -	- -	- -	- -	59.6	- -	- -	- -
Other/Mixed	- -	- -	- -	- -	- -	- -	- -	- -	- -	13.5	- -	- -	- -
Sexual orientation (2002 Survey)													
Heterosexual/Straight	42.4	0.0	0.0	2.7	38.1	39.6	27.5	31.7	88.9	25.0	- -	77.8	26.6
Homosexual - Gay male	40.7	67.7	76.6	83.8	42.9	39.6	39.2	41.5	0.0	50.0	- -	22.2	59.5
Homosexual - Lesbian	2.1	0.0	0.0	0.0	3.2	2.1	0.0	2.4	6.9	0.0	- -	0.0	2.5
Bisexual	13.6	32.3	23.4	13.5	15.9	14.6	29.4	19.5	2.8	25.0	- -	0.0	11.4
Other	1.2	0.0	0.0	0.0	0.0	4.2	3.9	4.9	1.4	0.0	- -	0.0	0.0
Sexual orientation (APLA)													
gay	77.6	87.6	93.4	89.8	- -	64.9	77.2	70.8	0.0	75.0	54.5	- -	- -
bisexual	8.1	12.4	6.6	10.2	- -	13.5	8.4	10.9	7.8	15.0	0.0	- -	- -
straight	14.1	0.0	0.0	0.0	- -	21.6	14.2	18.0	90.2	10.0	45.5	- -	- -
lesbian	0.2	0.0	0.0	0.0	- -	0.0	0.2	0.3	2.0	0.0	0.0	- -	- -
Sexual Orientation (SHAS)													
Het	54.5	15.7	4.1	22.1	55.8	60.9	43.9	57.2	- -	- -	- -	- -	- -
Homosexual	30.0	57.1	85.7	45.7	27.4	26.1	35.9	26.1	- -	- -	- -	- -	- -
Bisexual	12.2	20.0	8.2	27.9	12.6	13.0	14.8	10.6	- -	- -	- -	- -	- -
Marital Status (APLA)													
single	64.9	72.8	63.7	74.1	- -	66.7	64.9	62.5	43.4	68.0	63.6	- -	- -
legally married	4.1	0.7	0.7	2.1	- -	4.0	4.2	4.6	14.2	4.0	0.0	- -	- -
divorced	7.4	6.6	5.6	1.5	- -	8.0	6.9	10.4	20.8	4.0	9.1	- -	- -
widowed	1.8	2.2	2.2	0.3	- -	1.3	1.9	2.1	4.7	4.0	0.0	- -	- -
significant other	21.3	16.2	27.9	21.4	- -	17.3	21.7	19.5	16.0	20.0	18.2	- -	- -
other	0.4	1.5	0.0	0.6	- -	2.7	0.4	0.9	0.9	0.0	9.1	- -	- -
Marital Status (SHAS)													
Single	65.2	85.7	89.8	78.6	55.8	70.6	75.1	69.7	- -	- -	- -	- -	- -
Married / partnered	19.7	2.9	6.1	12.1	19.2	15.7	10.8	13.1	- -	- -	- -	- -	- -
Separated	4.5	1.4	2.0	3.6	8.7	2.0	3.7	6.6	- -	- -	- -	- -	- -
Divorced	6.9	5.7	2.0	3.6	8.7	7.8	7.1	6.6	- -	- -	- -	- -	- -
Widowed	3.7	4.3	0.0	2.1	7.7	3.9	3.3	4.0	- -	- -	- -	- -	- -
Marital Status (LAC-USC 5P21)													
Single	- -	82.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Married	- -	1.6	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Separated	- -	6.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Divorced	- -	6.0	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Widowed	- -	0.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Common-Law Marriage	- -	2.0	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Highest level of education (2002 Survey)													
Grade school or less	9.4	3.2	0.0	10.8	6.3	8.3	7.8	7.3	15.3	0.0	- -	33.3	8.8
Some high school	19.2	6.5	6.4	18.9	23.4	16.7	7.8	12.2	29.2	50.0	- -	22.2	16.3
Graduated High School/GED/trade school	29.8	25.8	29.8	29.7	31.3	35.4	29.4	39.0	31.9	0.0	- -	22.2	27.5
Some College / 2 year college degree	29.0	51.6	38.3	27.0	29.7	31.3	45.1	31.7	16.7	50.0	- -	11.1	31.3
Completed 4 year College	6.1	6.5	6.4	5.4	6.3	4.2	5.9	4.9	4.2	0.0	- -	5.6	7.5
Graduate Level	6.5	6.5	19.1	8.1	3.1	4.2	3.9	4.9	2.8	0.0	- -	5.6	8.8

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Highest level of education (APLA)		81.6											
11th or less	10.9	6.8	5.1	15.8	- -	11.0	10.4	13.8	25.7	21.7	18.2	- -	- -
high school	23.3	24.1	13.3	35.4	- -	32.9	23.1	25.6	28.6	34.8	18.2	- -	- -
1-3 yrs college	33.6	46.6	35.6	30.4	- -	34.2	34.3	39.7	26.7	21.7	27.3	- -	- -
college grad	19.2	14.3	27.5	13.0	- -	11.0	18.8	15.6	9.5	13.0	18.2	- -	- -
some grad schl	5.4	5.3	6.2	2.8	- -	6.8	5.9	2.8	7.6	4.3	18.2	- -	- -
grad degree	7.6	3.0	12.4	2.5	- -	4.1	7.6	2.5	1.9	4.3	0.0	- -	- -
Highest level of education (LAC-USC 5P21)													
Grade school or less	- -	2.4	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Some high school	- -	12.9	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Graduated High School/GED/trade school	- -	33.5	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Some College / 2 year college degree	- -	39.5	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Completed 4 year College	- -	8.9	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Graduate Level	- -	2.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Highest level of education (Transgender)													
< 12	- -	- -	- -	- -	- -	- -	- -	- -	- -	61.1	- -	- -	- -
12	- -	- -	- -	- -	- -	- -	- -	- -	- -	22.2	- -	- -	- -
>12	- -	- -	- -	- -	- -	- -	- -	- -	- -	16.7	- -	- -	- -
Where do you currently live? (2002 Survey)													
In my own apartment/house I own	8.5	0.0	17.4	8.3	4.7	4.2	4.1	7.5	11.8	0.0	- -	0.0	8.9
In my own apartment/house I rent	63.6	55.2	58.7	66.7	56.3	39.6	59.2	45.0	66.2	100.0	- -	75.0	62.0
At my parent's/relative's apt./house	7.6	3.4	2.2	11.1	9.4	2.1	10.2	5.0	7.4	0.0	- -	6.3	5.1
Crashing w/ someone w/out paying rent	3.4	10.3	4.3	2.8	6.3	4.2	6.1	2.5	1.5	0.0	- -	0.0	2.5
SRO	3.0	10.3	0.0	0.0	1.6	8.3	4.1	7.5	4.4	0.0	- -	0.0	2.5
In a "supportive living" facility	2.5	0.0	4.3	2.8	3.1	8.3	2.0	7.5	1.5	0.0	- -	0.0	5.1
Group home/residence (e.g residential drug tx)	4.2	10.3	6.5	2.8	9.4	14.6	6.1	12.5	2.9	0.0	- -	0.0	6.3
In a half-way house or transitional housing	3.0	3.4	6.5	2.8	3.1	6.3	4.1	10.0	1.5	0.0	- -	0.0	3.8
Skilled nursing home	0.8	0.0	0.0	2.8	0.0	2.1	0.0	0.0	0.0	0.0	- -	6.3	0.0
Homeless (on the street/in car)	1.3	0.0	0.0	0.0	3.1	4.2	2.0	0.0	0.0	0.0	- -	6.3	2.5
Homeless shelter	1.3	3.4	0.0	0.0	1.6	4.2	0.0	0.0	1.5	0.0	- -	0.0	0.0
Where do you currently live? (LAC-USC 5P21)													
living alone in a house/apt	- -	40.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
living w/ spouse/partner	- -	8.4	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
living w/ relatives	- -	24.4	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
living w/ friends	- -	14.0	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
homeless - living in a shelter or grp home	- -	5.2	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
not homeless - living in a shelter or group home	- -	4.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
homeless - not living in a shelter or group home	- -	2.4	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Living situation safe (2002 Survey)	91.6	85.2	95.6	96.2	95.0	83.7	88.1	86.5	93.0	33.3	- -	80.0	95.9
Living situation habitable (2002 Survey)	92.4	95.7	93.6	96.8	91.4	84.8	92.5	87.2	88.5	33.3	- -	60.0	94.4
Living situation stable (2002 Survey)	86.5	85.7	86.7	92.3	82.1	65.9	86.1	74.3	82.0	33.3	- -	54.5	88.1
Live alone (2002 Survey)	47.4	61.5	55.3	71.9	35.0	37.5	50.0	47.1	20.4	50.0	- -	25.0	55.6
# of other adults living at home (2002 Survey)													
One other adult	49.1	25.0	55.0	30.0	60.0	46.4	36.4	28.6	57.1	100.0	- -	55.6	51.4
2-3 other adults	31.6	41.7	20.0	20.0	20.0	17.9	40.9	33.3	33.3	0.0	- -	33.3	28.6
4+ other adults	19.3	33.3	25.0	50.0	20.0	35.7	22.7	38.1	9.5	0.0	- -	11.1	20.0
# of children living at home (2002 Survey)													
One child at home	39.4	50.0	16.7	0.0	43.8	33.3	27.3	45.5	43.2	0.0	- -	66.7	47.1
2-3 children	50.7	50.0	83.3	100.0	56.3	61.1	36.4	54.5	40.9	0.0	- -	22.2	52.9
4+ children	9.9	0.0	0.0	0.0	0.0	5.6	36.4	0.0	15.9	0.0	- -	11.1	0.0

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Time in half-way/transitional housing (2002 Survey)													
Never	82.1	80.6	83.0	78.4	80.0	66.7	80.4	70.7	83.3	75.0	- -	61.1	82.7
Less than a month	2.4	0.0	4.3	5.4	6.2	4.2	2.0	4.9	1.4	0.0	- -	0.0	4.9
1-3 months	4.9	3.2	8.5	2.7	7.7	18.8	5.9	17.1	1.4	0.0	- -	11.1	6.2
4 months to 1 yr.	6.1	6.5	2.1	8.1	4.6	6.3	7.8	4.9	8.3	25.0	- -	5.6	3.7
More than 1 yr.	4.5	9.7	2.1	5.4	1.5	4.2	3.9	2.4	5.6	0.0	- -	22.2	2.5
Time homeless (on the street/in car)? (2002 Survey)													
Never	86.2	87.1	80.9	83.8	67.7	29.2	86.3	48.8	93.1	100.0	- -	94.4	81.5
Less than a month	4.1	6.5	8.5	2.7	7.7	20.8	3.9	14.6	1.4	0.0	- -	5.6	6.2
1-3 months	4.1	0.0	4.3	8.1	9.2	20.8	5.9	12.2	4.2	0.0	- -	0.0	6.2
4 months to 1 yr.	3.3	3.2	4.3	5.4	9.2	16.7	2.0	12.2	1.4	0.0	- -	0.0	4.9
More than 1 yr.	2.4	3.2	2.1	0.0	6.2	12.5	2.0	12.2	0.0	0.0	- -	0.0	1.2
Time in a homeless shelter (2002 Survey)													
Never	88.6	87.1	89.4	81.1	84.6	41.7	90.2	63.4	87.5	75.0	- -	77.8	86.4
Less than a month	5.7	9.7	8.5	5.4	7.7	29.2	5.9	24.4	2.8	0.0	- -	0.0	8.6
1-3 months	2.4	3.2	2.1	8.1	3.1	12.5	2.0	4.9	1.4	25.0	- -	5.6	3.7
4 months to 1 yr.	1.6	0.0	0.0	2.7	3.1	8.3	0.0	4.9	4.2	0.0	- -	11.1	1.2
More than 1 yr.	1.6	0.0	0.0	2.7	1.5	8.3	2.0	2.4	4.2	0.0	- -	5.6	0.0
Time in a jail or correctional facility (2002 Survey)													
Never	83.7	74.2	78.7	81.1	70.8	47.9	76.5	2.4	94.4	75.0	- -	94.4	81.5
Less than a month	2.4	0.0	6.4	5.4	1.5	8.3	5.9	14.6	0.0	25.0	- -	5.6	2.5
1-3 months	3.7	6.5	8.5	2.7	9.2	16.7	3.9	22.0	1.4	0.0	- -	0.0	7.4
4 months to 1 yr.	5.7	9.7	6.4	8.1	9.2	12.5	7.8	34.1	2.8	0.0	- -	0.0	6.2
More than 1 yr.	4.5	9.7	0.0	2.7	9.2	14.6	5.9	26.8	1.4	0.0	- -	0.0	2.5
Ever been in Jail (SHAS)	33.3	41.4	28.6	27.9	61.5	51.0	64.3	99.0	- -	- -	- -	- -	- -
% ever been incarcerated (APLA)	24.8	40.0	22.0	20.5	- -	53.3	23.6	100.0	24.5	37.5	18.2	- -	- -
% ever been incarcerated (LAC-USC 5P21)	- -	63.2	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Homeless history (2002 Survey)	19.5	22.6	21.3	24.3	35.4	100.0	19.6	63.4	16.7	25.0	- -	27.8	23.5
Homeless in last six months (APLA)	5.7	8.8	3.6	5.5	- -	100.0	5.0	12.2	11.3	16.0	9.1	- -	- -
Risk of being homeless in next 3 months (APLA)	12.9	12.9	12.6	13.6	- -	49.3	12.0	16.0	8.6	16.7	20.0	- -	- -
Homeless history (LAC-USC 5P21)	- -	7.6	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Transitional housing history (2002 Survey)	27.2	32.3	23.4	27.0	38.5	0.0	25.5	48.8	27.8	25.0	- -	44.4	29.6
Currently employed (SHAS)	32.0	21.4	30.6	43.6	26.9	17.6	30.3	26.8	- -	- -	- -	- -	- -
Currently not employed (LAC-USC 5P21)	- -	88.4	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Current work situation (2002 Survey)													
Employed full-time	7.9	6.7	8.5	8.1	6.3	2.1	9.8	4.9	7.1	25.0	- -	11.1	3.8
Employed part-time	12.0	10.0	8.5	18.9	7.8	14.6	17.6	9.8	15.7	0.0	- -	27.8	13.9
Not working - looking for work	19.0	16.7	12.8	24.3	23.4	33.3	17.6	19.5	12.9	25.0	- -	33.3	16.5
Not working - student/homemaker	12.8	0.0	4.3	2.7	9.4	6.3	7.8	7.3	32.9	0.0	- -	16.7	8.9
Not working - not looking for work	38.8	60.0	46.8	35.1	42.2	37.5	41.2	53.7	27.1	50.0	- -	11.1	48.1
Retired	9.5	6.7	19.1	8.1	10.9	6.3	5.9	4.9	4.3	0.0	- -	0.0	8.9
% do sex work as a main source of income (TG)	- -	- -	- -	- -	- -	- -	- -	- -	- -	59.3	- -	- -	- -
Individual yearly income estimate (2002 Survey)													
$8,600 or less	52.4	60.0	30.4	59.4	47.5	61.4	58.3	55.3	57.6	66.7	- -	78.6	53.2
$8,601 - $11,600	28.4	36.7	37.0	25.0	39.3	25.0	25.0	31.6	21.2	0.0	- -	7.1	33.8
$11,601 - $16,500	9.3	0.0	8.7	6.3	4.9	13.6	8.3	13.2	12.1	33.3	- -	14.3	6.5
$16,501 - $23,200	2.7	0.0	6.5	3.1	0.0	0.0	2.1	0.0	3.0	0.0	- -	0.0	1.3
$23,201 - $26,000	1.8	3.3	2.2	3.1	0.0	0.0	2.1	0.0	1.5	0.0	- -	0.0	2.6
$26,001 - $35,000	2.2	0.0	8.7	0.0	1.6	0.0	2.1	0.0	0.0	0.0	- -	0.0	1.3
Greater than $35,001	3.1	0.0	6.5	3.1	6.6	0.0	2.1	0.0	4.5	0.0	- -	0.0	1.3

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Estimated Current Annual Income - before taxes (APLA)													
no income	8.0	6.1	4.0	12.2	- -	18.4	7.7	8.1	9.8	36.0	27.3	- -	- -
under $8,500	32.7	34.1	21.1	44.1	- -	51.3	32.3	38.1	45.1	56.0	36.4	- -	- -
$8,501-17,000	35.2	40.9	38.4	27.5	- -	26.3	35.3	36.3	34.3	8.0	9.1	- -	- -
$17,001-25,500	9.3	10.6	12.0	7.5	- -	2.6	9.2	8.4	7.8	0.0	18.2	- -	- -
$25,501-34,000	6.5	4.5	10.2	5.9	- -	0.0	6.8	5.3	0.0	0.0	9.1	- -	- -
over $34,000	8.3	3.8	14.4	2.8	- -	1.3	8.7	3.8	2.9	0.0	0.0	- -	- -
Household Income (LAC-USC 5P21)													
Less than $5,000	- -	47.6	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
$5000 - $9999	- -	26.4	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
$10000 - $14999	- -	14.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
$15000 - $24999	- -	6.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
$25000 - $34999	- -	1.2	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
$35000 - $49999	- -	1.6	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
$50000 - $74999	- -	0.4	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
$100000 and over	- -	0.4	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Income (Transgender)													
< $12,000	- -	- -	- -	- -	- -	- -	- -	- -	- -	68.5	- -	- -	- -
>= $12,000	- -	- -	- -	- -	- -	- -	- -	- -	- -	31.5	- -	- -	- -
FPL (OAPP Client Database)	90.6	95.5	91.5	92.9	96.2	91.9			91.4	92.1	98.2	- -	- -
FPL (APLA)	82.4	89.1	74.5	87.7		98.7	81.8	88.4	92.5	100.0	90.9	- -	- -
FPL (SHAS)	89.5	94.3	71.4	91.4	88.5	94.1	86.3	87.9	- -	- -	- -	- -	- -
FPL (LAC-USC 5P21)	- -	96.4	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Benefits Received (2002 Survey)													
Food stamps	18.7	16.1	6.4	5.4	16.9	39.6	17.6	24.4	33.3	0.0	- -	27.8	14.8
Supplemental Security Income (SSI)	39.4	45.2	36.2	32.4	50.8	27.1	35.3	39.0	33.3	50.0	- -	11.1	44.4
Public Health Service, Bureau of Indian Affairs (BIA)	0.8	0.0	0.0	0.0	1.5	0.0	2.0	0.0	0.0	0.0	- -	0.0	1.2
SDI	7.3	3.2	6.4	8.1	4.6	2.1	5.9	4.9	8.3	0.0	- -	0.0	7.4
SSDI	22.0	9.7	36.2	35.1	18.5	14.6	27.5	19.5	12.5	0.0	- -	0.0	37.0
VA Benefits	1.6	3.2	2.1	2.7	0.0	4.2	2.0	2.4	1.4	0.0	- -	0.0	0.0
CHAMPUS	0.4	0.0	0.0	0.0	1.5	0.0	0.0	0.0	0.0	0.0	- -	0.0	0.0
Annuity/Life insurance payments	0.4	0.0	2.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	- -	0.0	1.2
Retirement	4.9	0.0	17.0	5.4	3.1	2.1	3.9	2.4	1.4	25.0	- -	5.6	1.2
Rent Supplement	11.4	9.7	14.9	10.8	9.2	4.2	13.7	9.8	11.1	0.0	- -	11.1	12.3
Subsidized housing	33.3	25.8	34.0	40.5	29.2	39.6	33.3	39.0	37.5	50.0	- -	22.2	43.2
General Assistance	9.3	12.9	12.8	8.1	16.9	27.1	9.8	22.0	5.6	0.0	- -	0.0	12.3
Emergency Financial Assistance	2.4	0.0	6.4	2.7	1.5	4.2	3.9	0.0	2.8	0.0	- -	5.6	3.7
WIC	5.7	0.0	2.1	5.4	4.6	4.2	3.9	2.4	13.9	0.0	- -	16.7	3.7
TANF / CalWorks	7.7	0.0	2.1	2.7	4.6	12.5	9.8	4.9	23.6	0.0	- -	16.7	7.4
Health Care Provider / Location (OAPP Client Database)													
Public	37.6	43.3	43.5	49.0	41.7	44.3	- -	- -	44.1	41.1	22.3	- -	- -
Private	32.2	31.0	37.9	37.2	21.3	30.6	- -	- -	22.5	32.9	9.5	- -	- -
Hospital outpatient care	15.4	17.1	9.1	8.1	22.1	9.7	- -	- -	21.0	12.7	47.3	- -	- -
Emergency room	0.2	0.0	0.1	0.0	0.1	0.2	- -	- -	0.3	0.0	0.5	- -	- -
No primary source	3.2	4.0	3.5	1.9	9.6	9.0	- -	- -	3.1	7.0	2.3	- -	- -
Unknown	11.1	4.7	5.7	3.8	5.1	6.1	- -	- -	9.0	6.3	18.2	- -	- -

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Form of Health Insurance (OAPP Client Database)													
Private	6.5	5.3	12.0	5.9	4.7	2.5	- -	- -	5.7	1.4	6.6	- -	- -
Medicare	5.4	10.5	9.2	6.2	7.0	6.5	- -	- -	3.1	4.8	0.0	- -	- -
Medicaid	23.0	31.1	19.5	14.5	33.7	28.8	- -	- -	37.0	28.8	52.6	- -	- -
Other pub	3.5	2.7	3.0	4.8	3.5	2.9	- -	- -	3.3	6.8	0.9	- -	- -
No insurance	42.4	43.7	50.7	61.7	43.9	50.2	- -	- -	35.6	51.4	25.1	- -	- -
Other	2.2	1.3	0.9	2.3	1.8	2.2	- -	- -	4.2	1.4	4.3	- -	- -
Unknown	17.0	5.4	4.6	4.5	5.4	6.9	- -	- -	11.1	5.5	10.4	- -	- -
Form of Health Insurance (2002 Survey)													
Private insurance through work	6.9	6.5	12.8	8.1	6.2	4.2	5.9	2.4	5.6	25.0	- -	11.1	3.7
COBRA or OBRA	1.2	3.2	0.0	0.0	1.5	2.1	2.0	0.0	2.8	0.0	- -	0.0	1.2
Private insurance not through work	4.5	9.7	8.5	5.4	6.2	6.3	7.8	7.3	1.4	0.0	- -	0.0	7.4
Medicare	25.6	25.8	29.8	29.7	24.6	12.5	25.5	19.5	13.9	0.0	- -	0.0	35.8
Medi-Cal / Medicaid	52.0	41.9	53.2	56.8	52.3	37.5	54.9	46.3	55.6	100.0	- -	22.2	61.7
Form of Health Insurance (APLA)													
Private Plan (self-pay)	9.1	3.6	14.3	4.0	- -	4.0	9.2	5.3	4.9	0.0	9.1	- -	- -
Medicare	38.2	43.8	41.0	30.5	- -	26.7	38.0	36.5	36.9	20.8	9.1	- -	- -
Private Plan (employer-pay)	8.5	7.3	12.5	6.2	- -	2.7	8.4	6.8	3.9	0.0	9.1	- -	- -
Medi-Cal	43.8	48.2	38.3	38.5	- -	42.7	43.2	51.7	64.1	58.3	9.1	- -	- -
No Insurance	19.5	17.5	14.6	33.5	- -	37.3	20.1	20.7	13.6	29.2	45.5	- -	- -
HMO	11.2	8.0	15.9	9.2	- -	4.0	11.4	7.7	3.9	8.3	9.1	- -	- -
Veteran's Administration	2.9	7.3	3.2	0.3	- -	4.0	2.3	5.6	0.0	0.0	0.0	- -	- -
Form of Health Insurance (SHAS)													
Medicaid	66.3	76.2	52.2	57.1	65.4	68.6	52.3	50.0	- -	- -	- -	- -	- -
Medicare	8.1	17.4	14.6	2.0	69.9	70.5	59.3	61.1	- -	- -	- -	- -	- -
Private Insurance	10.1	12.8	26.2	9.6	15.7	11.4	7.9	8.2	- -	- -	- -	- -	- -
Veteran's Administration	3.0	6.7	12.2	2.0	6.0	5.6	7.5	3.1	- -	- -	- -	- -	- -
Other health coverage	7.5	2.2	4.9	7.5	6.2	2.9	4.1	3.1	- -	- -	- -	- -	- -
Form of Health Insurance (LAC-USC 5P21)													
Medi-Cal or Medicaid	- -	77.9	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
State-funded assistance programs	- -	16.1	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Private Insurance (paid by employer)	- -	0.5	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Medicare	- -	2.3	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
VA	- -	2.3	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
COBRA	- -	0.5	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
% w/ health insurance (2002 Survey)	72.0	67.7	83.0	67.6	76.9	50.0	70.6	70.7	70.8	100.0	- -	33.3	81.5
% w/o health insurance (2002 Survey)	28.0	32.3	17.0	32.4	16.9	50.0	29.4	29.3	29.2	0.0	- -	66.7	18.5
Currently have health insurance (SHAS)	70.0	81.4	73.5	60.0	76.9	70.6	70.1	67.2	- -	- -	- -	- -	- -
Currently have health insurance (LAC-USC 5P21)	- -	87.6	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Currently do not have health insurance (LAC-USC 5P21)	- -	12.4	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Medical care site (SHAS)													
private dr.	9.7	14.3	28.6	9.3	7.7	3.9	9.1	5.6	- -	- -	- -	- -	- -
community clinic, public health clinic, or co. health clinic	88.2	80.0	63.3	90.0	87.5	92.2	87.1	90.9	- -	- -	- -	- -	- -
VA hospital	1.3	2.9	6.1	0.7	0.0	0.0	0.0	0.0	- -	- -	- -	- -	- -
HMO site	0.6	1.4	2.0	- -	2.9	2.0	2.5	2.0	- -	- -	- -	- -	- -
other facility	0.2	1.4	- -	- -	0.0	0.0	0.4	0.5	- -	- -	- -	- -	- -
Years w/ HIV (2002 Survey)													
Less than 1 year	5.3	7.1	4.3	3.0	1.6	12.8	9.3	7.7	1.5	0.0	- -	11.8	5.3
1 to 3 years	10.6	17.9	8.7	15.2	6.3	17.0	16.3	17.9	12.3	33.3	- -	23.5	8.0
3 to 8 years	35.2	21.4	26.1	27.3	34.9	29.8	27.9	23.1	47.7	33.3	- -	47.1	29.3
More than 8 years	48.9	53.6	60.9	54.5	57.1	40.4	46.5	51.3	38.5	33.3	- -	17.6	57.3

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Years w/ HIV (APLA)													
Less than 1 year	7.3	8.7	4.4	11.1	- -	15.5	7.4	5.4	6.7	13.0	22.2	- -	- -
1 to 3 years	8.9	9.5	6.7	12.4	- -	9.9	9.2	8.0	8.7	8.7	44.4	- -	- -
3 to 8 years	32.0	35.7	25.7	32.4	- -	35.2	31.8	32.7	51.9	34.8	22.2	- -	- -
More than 8 years	51.9	46.0	63.1	44.1	- -	39.4	51.6	53.8	32.7	43.5	11.1	- -	- -
Years w/ HIV (APLA)													
Less than 3 years	16.1	18.3	11.1	23.5	- -	25.4	16.6	13.5	15.4	21.7	66.7	- -	- -
3 to 6 years	19.4	20.6	15.2	19.4	- -	23.9	19.4	18.6	34.6	17.4	22.2	- -	- -
6 to 12 years	38.4	39.7	38.9	38.4	- -	38.0	38.1	40.1	37.5	39.1	11.1	- -	- -
More than 12 years	26.0	21.4	34.8	18.7	- -	12.7	25.9	27.9	12.5	21.7	0.0	- -	- -
Years w/ HIV (SHAS)													
Less than 3 years	55.1	31.7	30.4	68.9	39.1	52.5	51.2	53.9	- -	- -	- -	- -	- -
3 -6 years	17.2	18.3	19.6	11.5	10.3	10.0	15.5	13.2	- -	- -	- -	- -	- -
7 -12 years	19.1	33.3	26.1	14.8	28.7	32.5	21.6	22.8	- -	- -	- -	- -	- -
12+ years	8.5	16.7	23.9	4.9	21.8	5.0	11.7	10.2	- -	- -	- -	- -	- -
Length w/ HIV (LAC-USC 5P21)													
1 to 3 years	- -	8.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
3 to 8 years	- -	42.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
More than 8 years	- -	48.4	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Risk (OAPP Client Database)													
MSM	52.9	92.8	92.2	96.0	52.9	41.9	- -	- -	0.0	45.0	13.7	- -	- -
MSM/IDU	3.5	7.2	7.8	4.0	3.5	8.1	- -	- -	0.0	9.4	0.0	- -	- -
IDU	5.5	0.0	0.0	0.0	5.5	11.3	- -	- -	11.4	3.5	0.6	- -	- -
Heterosexual/Straight	23.0	0.0	0.0	0.0	22.8	21.0	- -	- -	68.9	14.6	18.9	- -	- -
Hemo	0.9	0.0	0.0	0.0	0.9	0.8	- -	- -	2.3	0.0	20.0	- -	- -
Ped	3.4	0.0	0.0	0.0	3.4	0.8	- -	- -	1.2	0.0	26.9	- -	- -
Other	2.3	0.0	0.0	0.0	2.3	3.8	- -	- -	1.3	0.6	8.0	- -	- -
Unknown	8.5	0.0	0.0	0.0	8.6	12.1	- -	- -	14.8	26.9	12.0	- -	- -
Most likely way infected with HIV (2002 Survey)													
Having sex with a man	65.2	80.0	72.3	89.2	36.9	64.6	74.0	58.5	80.3	75.0	- -	55.6	67.9
Having sex with a woman	6.1	0.0	0.0	0.0	3.1	4.2	6.0	4.9	1.4	0.0	- -	27.8	2.5
Having sex with a transgender	1.2	3.3	2.1	0.0	3.1	4.2	2.0	4.9	1.4	0.0	- -	5.6	2.5
Sharing needles	13.5	3.3	21.3	2.7	50.8	22.9	0.0	26.8	2.8	25.0	- -	0.0	17.3
Blood transfusions or products/Hemophilia	5.3	10.0	0.0	0.0	1.5	2.1	10.0	2.4	5.6	0.0	- -	11.1	0.0
Acquired at birth	0.8	0.0	0.0	0.0	0.0	0.0	2.0	0.0	2.8	0.0	- -	0.0	1.2
Other	0.4	0.0	0.0	2.7	0.0	0.0	0.0	0.0	0.0	0.0	- -	0.0	0.0
Don't know	7.4	3.3	4.3	5.4	4.6	2.1	6.0	2.4	5.6	0.0	- -	0.0	8.6
Received AIDS diagnosis (2002 Survey)	54.5	51.6	66.0	59.5	58.5	33.3	45.1	31.7	45.8	75.0	- -	50.0	60.5
Years w/ AIDS (2002 Survey)													
Less than 3 years	29.0	43.8	20.0	35.0	24.3	50.0	34.8	46.2	27.3	50.0	- -	25.0	25.0
3 to 6 years	31.3	31.3	26.7	25.0	27.0	18.8	34.8	23.1	39.4	0.0	- -	62.5	20.8
6 to 12 years	35.1	18.8	43.3	40.0	45.9	31.3	21.7	30.8	30.3	0.0	- -	12.5	50.0
More than 12 years	4.6	6.3	10.0	0.0	2.7	0.0	8.7	0.0	3.0	50.0	- -	0.0	4.2
Physical health is… (SHAS)													
Excellent	10.1	11.4	12.2	10.7	6.7	0.0	12.4	10.1	- -	- -	- -	- -	- -
Very Good	10.3	11.4	22.4	9.3	11.5	7.8	17.8	13.6	- -	- -	- -	- -	- -
Good	22.5	17.1	20.4	27.9	23.1	23.5	27.8	28.3	- -	- -	- -	- -	- -
Fair	19.9	21.4	24.5	15.0	26.9	25.5	31.5	37.4	- -	- -	- -	- -	- -
Poor	6.0	2.9	4.1	7.9	9.6	11.8	10.4	9.6	- -	- -	- -	- -	- -

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Physical health is… (2002 Survey)													
Excellent	15.2	10.0	14.9	11.1	16.9	6.3	12.0	9.8	19.4	25.0	- -	16.7	12.3
Good	38.7	40.0	42.6	33.3	41.5	54.2	40.0	53.7	41.7	25.0	- -	33.3	39.5
Fair	36.6	36.7	38.3	41.7	36.9	29.2	36.0	29.3	29.2	25.0	- -	38.9	40.7
Poor	9.5	13.3	4.3	13.9	4.6	10.4	12.0	7.3	9.7	25.0	- -	11.1	7.4
General Health is… (APLA)													
Excellent	10.4	9.0	10.7	10.5	- -	5.3	10.7	9.9	10.4	8.3	36.4	- -	- -
Good	60.1	67.2	61.3	64.0	- -	55.3	59.9	59.3	49.1	58.3	63.6	- -	- -
Fair	22.8	21.6	22.0	19.2	- -	26.3	22.6	24.4	34.0	16.7	0.0	- -	- -
Poor	6.7	2.2	6.0	6.3	- -	13.2	6.8	6.5	6.6	16.7	0.0	- -	- -
Compare your physical health (2002 Survey)													
Much worse	6.6	3.3	12.8	8.3	4.6	4.2	8.2	2.4	5.7	0.0	- -	0.0	8.8
A little worse	13.3	13.3	19.1	16.7	15.4	14.6	8.2	17.1	8.6	0.0	- -	5.6	18.8
About the same	19.5	23.3	14.9	19.4	20.0	25.0	26.5	22.0	18.6	25.0	- -	11.1	17.5
A little better	21.2	26.7	14.9	27.8	23.1	18.8	30.6	14.6	18.6	25.0	- -	27.8	15.0
Much better	39.4	33.3	38.3	27.8	36.9	37.5	26.5	43.9	48.6	50.0	- -	55.6	40.0
Compare health in general now to a yr ago (APLA)													
better than 1 yr ago	29.6	40.7	22.6	37.0	- -	17.1	29.9	26.1	32.4	44.0	54.5	- -	- -
about the same as 1 yr ago	52.8	43.7	56.5	51.2	- -	51.3	52.5	54.9	53.3	48.0	45.5	- -	- -
worse than 1 yr ago	17.6	15.6	20.8	11.7	- -	31.6	17.6	19.0	14.3	8.0	0.0	- -	- -
Emotional health is… (2002 Survey)													
Poor	9.9	16.7	8.5	11.1	7.7	12.5	14.0	9.8	6.9	25.0	- -	5.6	14.8
Fair	35.4	36.7	27.7	38.9	35.4	31.3	48.0	31.7	38.9	50.0	- -	22.2	43.2
Good	37.9	40.0	40.4	41.7	47.7	45.8	32.0	46.3	30.6	25.0	- -	55.6	35.8
Excellent	16.9	6.7	23.4	8.3	9.2	10.4	6.0	12.2	23.6	0.0	- -	16.7	6.2
Compare your emotional health (2002 Survey)													
Much worse	5.0	13.3	0.0	8.8	4.6	2.1	4.1	4.9	2.9	0.0	- -	12.5	5.0
A little worse	12.2	10.0	12.8	14.7	10.8	12.5	12.2	7.3	12.9	50.0	- -	0.0	17.5
About the same	18.9	23.3	19.1	11.8	24.6	20.8	18.4	29.3	11.4	0.0	- -	6.3	21.3
A little better	24.8	33.3	14.9	38.2	23.1	25.0	36.7	22.0	25.7	25.0	- -	37.5	23.8
Much better	39.1	20.0	53.2	26.5	36.9	39.6	28.6	36.6	47.1	25.0	- -	43.8	32.5
Most recent T-cell / CD-4 count (SHAS)													
less than 200	33.1	34.3	36.7	40.7	29.8	31.4	31.5	27.3	- -	- -	- -	- -	- -
200-499	29.2	34.3	38.8	27.9	38.5	27.5	33.6	29.8	- -	- -	- -	- -	- -
500 or more	6.9	11.4	14.3	5.7	12.5	15.7	10.8	7.6	- -	- -	- -	- -	- -
Don't Know	27.0	20.0	10.2	20.0	18.3	23.5	21.2	30.8	- -	- -	- -	- -	- -
Tested positive for TB skin test (SHAS)	16.3	14.3	12.2	17.9	28.8	29.4	18.7	24.2	- -	- -	- -	- -	- -
Active TB (SHAS)	4.3	1.4	0.0	4.3	3.8	5.9	4.1	4.5	- -	- -	- -	- -	- -
STD Diagnosis (LAC-USC 5P21)													
Genital Gonorrhea	- -	66.3	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Oral Gonorrhea	- -	1.6	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Rectal Gonorrhea	- -	15.3	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Syphilis	- -	36.1	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Chlamydia	- -	5.6	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Genital Warts	- -	6.8	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Rectal Warts	- -	9.6	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Genital Herpes	- -	7.6	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Rectal Herpes	- -	4.0	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Hepatitis B	- -	12.4	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
STD Diagnosis in last year (2002 Survey)													
Hepatitis A or B	15.9	12.9	14.9	24.3	29.2	25.0	9.8	26.8	11.1	25.0	- -	33.3	19.8
Hepatitis C	15.0	16.1	10.6	13.5	40.0	25.0	5.9	24.4	6.9	25.0	- -	11.1	23.5
Syphilis	7.3	12.9	4.3	8.1	7.7	10.4	0.0	7.3	5.6	0.0	- -	11.1	4.9
Herpes (genital)	8.9	6.5	12.8	10.8	12.3	6.3	9.8	2.4	5.6	0.0	- -	5.6	16.0
Gonorrhea	2.4	3.2	4.3	0.0	4.6	4.2	2.0	7.3	1.4	0.0	- -	5.6	3.7
Chlamydia	4.1	3.2	4.3	0.0	4.6	10.4	3.9	7.3	8.3	0.0	- -	5.6	6.2
Genital warts	8.1	9.7	10.6	8.1	7.7	8.3	9.8	2.4	9.7	25.0	- -	11.1	14.8
Yeast infections	12.2	3.2	10.9	2.7	10.8	16.7	7.8	12.2	29.2	0.0	- -	11.1	18.8
STD Diagnosis (SHAS)													
Gonorrhea	30.6	41.4	46.9	25.7	47.1	33.3	41.1	24.1	- -	- -	- -	- -	- -
Syphilis	22.0	40.0	26.5	22.9	32.7	25.5	27.4	27.8	- -	- -	- -	- -	- -
Hepatitis B	9.0	24.0	37.5	4.9	13.0	6.3	0.0	0.0	- -	- -	- -	- -	- -
Genital warts	12.6	8.0	0.0	9.8	17.4	18.8	0.0	0.0	- -	- -	- -	- -	- -
Genital Herpes	1.2	8.0	12.5	14.6	0.0	0.0	0.0	0.0	- -	- -	- -	- -	- -
Rectal Herpes	10.8	4.0	12.5	0.0	39.1	12.5	0.0	0.0	- -	- -	- -	- -	- -
Taking antiretrovirals / protease inhibitors (2002 Survey)	61.8	48.4	76.6	67.6	73.8	58.3	60.8	68.3	55.6	50.0	- -	55.6	66.7
Taking antibiotics (2002 Survey)	30.9	22.6	42.6	35.1	35.4	27.1	33.3	34.1	26.4	75.0	- -	22.2	40.7
Currently prescribed medications (APLA)	85.7	90.1	89.2	82.9	- -	73.0	86.0	81.4	76.5	81.0	44.4	- -	- -
Skipped medications... (2002 Survey)													
Never/ Have not skipped	32.6	20.8	28.3	27.3	25.0	25.0	30.4	23.1	31.7	0.0	- -	23.5	31.1
Once or twice a month	32.6	20.8	47.8	36.4	30.0	18.2	28.3	23.1	33.3	50.0	- -	35.3	36.5
Once or twice a week	14.5	29.2	10.9	15.2	16.7	27.3	23.9	28.2	12.7	25.0	- -	5.9	9.5
More than twice a week	6.8	12.5	4.3	12.1	5.0	6.8	13.0	10.3	3.2	0.0	- -	5.9	5.4
I have stopped taking my medicine	13.6	16.7	8.7	9.1	23.3	22.7	4.3	15.4	19.0	25.0	- -	29.4	17.6
Reasons for skipping medications (2002 Survey)													
Side effects	21.5	22.6	19.1	21.6	21.5	18.8	25.5	17.1	30.6	25.0	- -	16.7	24.7
Difficult schedule	17.1	22.6	12.8	18.9	23.1	14.6	13.7	17.1	16.7	25.0	- -	11.1	17.3
Didn't want others to see the meds	10.6	12.9	4.3	8.1	12.3	16.7	9.8	14.6	15.3	50.0	- -	11.1	12.3
Didn't understand directions	5.3	6.5	0.0	8.1	3.1	6.3	5.9	7.3	6.9	0.0	- -	5.6	8.6
Feel that medications didnt work	4.9	6.5	2.1	2.7	6.2	8.3	7.8	4.9	8.3	25.0	- -	5.6	2.5
Affordability	3.3	0.0	0.0	5.4	0.0	6.3	7.8	7.3	5.6	0.0	- -	0.0	1.2
Forgot	38.2	29.0	44.7	40.5	44.6	45.8	43.1	48.8	34.7	50.0	- -	33.3	44.4
Ran out	9.3	25.8	6.4	5.4	10.8	16.7	11.8	22.0	8.3	0.0	- -	5.6	9.9
Hard to coordinate with food	15.1	25.8	17.0	18.9	21.5	14.6	17.6	17.1	11.3	50.0	- -	27.8	17.3
Didn't want to take them	20.7	12.9	25.5	27.0	29.2	29.2	19.6	24.4	18.1	75.0	- -	11.1	27.2
Homeless	7.7	9.7	8.5	5.4	16.9	27.1	7.8	22.0	6.9	0.0	- -	5.6	11.1
Felt didn't need meds anymore	4.9	3.2	2.1	5.4	3.1	4.2	2.0	2.4	6.9	0.0	- -	11.1	4.9
Doctor advised me to stop	8.5	9.7	6.4	8.1	9.2	10.4	5.9	4.9	15.3	0.0	- -	11.1	12.3
Side effects have bothered me (APLA)													
No side effects	24.3	31.1	23.4	24.2	- -	14.1	24.1	24.0	18.6	28.6	50.0	- -	- -
Yes, a little bit	40.7	39.3	41.5	42.5	- -	42.2	40.7	40.6	40.7	19.0	33.3	- -	- -
Yes, a lot	20.1	15.6	22.8	16.8	- -	18.8	20.4	19.1	16.3	9.5	0.0	- -	- -
Yes, terribly	8.1	7.4	9.9	5.6	- -	12.5	8.2	8.5	7.0	23.8	16.7	- -	- -
Ever taken antiretroviral meds to treat HIV (SHAS)	95.3	95.7	100.0	92.9	94.2	96.1	92.9	92.4	- -	- -	- -	- -	- -
Not able to take med (SHAS)	26.0	31.4	16.3	26.4	20.2	25.5	0.0	1.0	- -	- -	- -	- -	- -
How often were you able to take meds exactly the way doctor told you to take them? (SHAS)													
Rarely or never	1.3	0.0	2.0	2.1	1.9	0.0	1.7	1.0	- -	- -	- -	- -	- -
Sometimes	5.6	7.1	2.0	5.7	6.7	0.0	6.6	9.1	- -	- -	- -	- -	- -
Usually	19.1	17.1	40.8	14.3	22.1	23.5	26.1	24.2	- -	- -	- -	- -	- -
Always	64.8	62.9	51.0	68.6	53.8	56.9	51.9	51.5	- -	- -	- -	- -	- -

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Adherence (SHAS)													
I often forget to take them	11.6	12.9	32.7	8.6	7.7	3.9	9.5	7.6	- -	- -	- -	- -	- -
I can't afford the medications	0.2	4.3	18.4	3.6	0.0	2.0	1.7	2.0	- -	- -	- -	- -	- -
I can't fit the schedule for taking them into my daily life	6.4	4.3	18.4	3.6	1.9	0.0	0.8	1.0	- -	- -	- -	- -	- -
Side Effects	5.4	7.1	4.1	6.4	5.8	5.9	5.0	6.6	- -	- -	- -	- -	- -
I sold them so I could get money	0.2	0.0	0.0	0.0	18.3	13.7	15.8	16.2	- -	- -	- -	- -	- -
Adherence (SHAS) - continued…													
I'm on too many medications	0.8	0.0	0.0	0.0	1.0	0.0	2.1	2.0	- -	- -	- -	- -	- -
I can't get to the clinic or pharmacy to get the medications	0.4	0.0	0.0	0.0	0.0	2.0	0.8	1.0	- -	- -	- -	- -	- -
I can't get to the doctor to gt my prescriptions for refills	0.6	0.0	0.0	0.7	0.0	0.0	0.8	1.0	- -	- -	- -	- -	- -
When I go back on the street, I don't think about taking my medications.	0.2	0.0	0.0	0.7	0.0	0.0	0.4	0.0	- -	- -	- -	- -	- -
I get depressed and give up on trying to fight my illness.	0.4	0.0	0.0	1.4	0.0	0.0	0.4	0.5	- -	- -	- -	- -	- -
I don't believe in taking medications.	0.2	0.0	0.0	0.0	0.0	0.0	0.8	0.5	- -	- -	- -	- -	- -
I think these drugs are poisonous.	0.4	0.0	0.0	0.0	1.0	0.0	0.0	0.0	- -	- -	- -	- -	- -
I couldn't get my drugs on schedule because I was in jail / prison.	0.2	0.0	0.0	0.0	1.0	0.0	0.0	0.0	- -	- -	- -	- -	- -
I have stopped taking my prescribed medications (SHAS)	47.6	62.9	69.4	43.6	0.0	0.0	0.4	0.5	- -	- -	- -	- -	- -
Received mental health service (2002 Survey)	56.5	61.3	72.3	62.2	67.7	56.3	64.7	51.2	48.6	75.0	- -	38.9	92.6
Inpatient (in a hospital at least overnight)	13.0	9.7	17.0	13.5	26.2	12.5	9.8	19.5	12.5	25.0	- -	11.1	39.5
Individual counseling/therapy	50.4	51.6	59.6	51.4	66.2	52.1	51.0	39.0	45.8	50.0	- -	22.2	80.2
Group counseling/therapy	37.4	38.7	53.2	32.4	47.7	41.7	33.3	41.5	30.6	0.0	- -	11.1	53.1
Taken mental related medicines	28.5	25.8	51.1	40.5	41.5	35.4	31.4	31.7	13.9	50.0	- -	5.6	80.2
In the last two years, received … (2002 Survey)													
Anxiety diagnosis	34.1	35.5	51.1	37.8	43.1	31.3	33.3	29.3	27.8	50.0	- -	22.2	61.7
Bipolar disorder	7.3	16.1	6.4	5.4	12.3	14.6	13.7	9.8	2.8	0.0	- -	5.6	13.6
Dementia depression	2.8	0.0	0.0	10.8	0.0	0.0	3.9	2.4	1.4	0.0	- -	5.6	4.9
Depression diagnosis	50.4	67.7	57.4	56.8	56.9	56.3	52.9	56.1	40.3	50.0	- -	27.8	86.4
Alcohol (2002 Survey)		38.7											
Not used in yr	56.1	58.1	29.8	67.6	47.7	43.8	29.4	36.6	65.3	50.0	- -	44.4	49.4
Not used in last six months	6.5	3.2	2.1	8.1	7.7	10.4	3.9	12.2	8.3	0.0	- -	33.3	6.2
Used in last 6 months	10.2	6.5	12.8	2.7	12.3	20.8	13.7	9.8	12.5	0.0	- -	11.1	9.9
Used less than once a month	8.9	6.5	17.0	8.1	7.7	4.2	13.7	4.9	6.9	0.0	- -	0.0	9.9
Used at least once a month	9.8	6.5	29.8	5.4	10.8	10.4	15.7	17.1	4.2	0.0	- -	11.1	13.6
Used once a week or more	8.5	19.4	8.5	8.1	13.8	10.4	23.5	19.5	2.8	50.0	- -	0.0	11.1
Marijuana (2002 Survey)													
Not used in yr	68.7	77.4	51.1	70.3	50.8	56.3	35.3	46.3	81.9	100.0	- -	72.2	64.2
Not used in last six months	4.1	3.2	0.0	8.1	6.2	6.3	2.0	9.8	2.8	0.0	- -	22.2	3.7
Used in last 6 months	8.5	3.2	17.0	10.8	15.4	12.5	11.8	9.8	2.8	0.0	- -	5.6	12.3
Used less than once a month	2.4	0.0	4.3	0.0	4.6	4.2	2.0	4.9	2.8	0.0	- -	0.0	2.5
Used at least once a month	5.3	3.2	8.5	2.7	4.6	4.2	19.6	4.9	2.8	0.0	- -	0.0	4.9
Used once a week or more	11.0	12.9	19.1	8.1	18.5	16.7	29.4	24.4	6.9	0.0	- -	0.0	12.3
Marijuana (APLA)													
never used	62.0	43.7	55.5	73.1	- -	48.5	61.5	53.5	75.5	64.7	90.0	- -	- -
once a month	10.9	16.7	12.6	9.0	- -	11.8	10.4	11.0	5.1	0.0	0.0	- -	- -
2 or 3 times a month	6.3	15.9	7.2	4.3	- -	10.3	5.9	7.4	1.0	5.9	0.0	- -	- -
1 or 2 times a month	6.6	7.1	7.4	5.6	- -	16.2	7.1	9.0	7.1	5.9	10.0	- -	- -
nearly every day	8.4	11.1	10.4	4.7	- -	5.9	9.0	10.6	4.1	11.8	0.0	- -	- -
at least daily	5.8	5.6	6.9	3.3	- -	7.4	6.2	8.4	7.1	11.8	0.0	- -	- -

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Crack (2002 Survey)													
Not used in yr	84.1	77.4	78.7	81.1	73.8	66.7	64.7	65.9	91.7	100.0	- -	72.2	76.5
Not used in last six months	4.5	6.5	2.1	10.8	6.2	8.3	5.9	12.2	2.8	0.0	- -	22.2	6.2
Used in last 6 months	4.1	6.5	4.3	5.4	4.6	4.2	13.7	7.3	2.8	0.0	- -	0.0	7.4
Used less than once a month	1.6	0.0	4.3	0.0	3.1	4.2	3.9	2.4	1.4	0.0	- -	5.6	2.5
Used at least once a month	2.0	0.0	6.4	2.7	4.6	6.3	3.9	4.9	0.0	0.0	- -	0.0	4.9
Used once a week or more	3.7	9.7	4.3	0.0	7.7	10.4	7.8	7.3	1.4	0.0	- -	0.0	2.5
Crack (APLA)													
never used	93.9	81.6	96.9	95.7	- -	80.6	95.0	87.1	94.1	94.4	90.0	- -	- -
once a month	2.6	4.8	1.7	1.3	- -	4.5	2.2	5.2	3.0	0.0	0.0	- -	- -
2 or 3 times a month	1.8	4.0	1.1	2.0	- -	6.0	1.4	3.5	2.0	0.0	10.0	- -	- -
1 or 2 times a month	1.0	6.4	0.0	0.7	- -	6.0	1.0	2.6	0.0	0.0	0.0	- -	- -
nearly every day	0.3	0.8	0.2	0.3	- -	0.0	0.3	0.6	1.0	0.0	0.0	- -	- -
at least daily	0.3	2.4	0.0	0.0	- -	3.0	0.2	1.0	0.0	5.6	0.0	- -	- -
Heroin (2002 Survey)													
Not used in yr	90.7	93.5	85.1	89.2	78.5	85.4	90.2	78.0	95.8	100.0	- -	77.8	86.4
Not used in last six months	4.1	6.5	2.1	8.1	7.7	6.3	2.0	12.2	1.4	0.0	- -	22.2	6.2
Used in last 6 months	2.8	0.0	6.4	2.7	7.7	0.0	3.9	0.0	0.0	0.0	- -	0.0	4.9
Used less than once a month	0.8	0.0	2.1	0.0	1.5	2.1	2.0	2.4	1.4	0.0	- -	0.0	1.2
Used at least once a month	0.8	0.0	4.3	0.0	1.5	4.2	2.0	4.9	0.0	0.0	- -	0.0	1.2
Used once a week or more	0.8	0.0	0.0	0.0	3.1	2.1	0.0	2.4	1.4	0.0	- -	0.0	0.0
Heroin (APLA)													
never used	99.2	98.4	99.8	99.0	- -	97.1	99.5	97.7	100.0	100.0	100.0	- -	- -
once a month	0.6	1.6	0.2	0.3	- -	2.9	0.5	1.3	0.0	0.0	0.0	- -	- -
nearly every day	0.2	0.0	0.0	0.3	- -	0.0	0.0	0.6	0.0	0.0	0.0	- -	- -
at least daily	0.1	0.0	0.0	0.3	- -	0.0	0.0	0.3	0.0	0.0	0.0	- -	- -
Cocaine (APLA)													
never used	93.7	92.0	94.7	90.8	- -	88.4	93.9	90.9	98.0	88.9	90.0	- -	- -
once a month	4.1	3.2	4.4	4.6	- -	10.1	4.1	5.5	2.0	5.6	10.0	- -	- -
2 or 3 times a month	1.4	2.4	0.8	3.3	- -	0.0	1.3	1.9	0.0	0.0	0.0	- -	- -
1 or 2 times a month	0.6	0.8	0.2	1.3	- -	1.4	0.4	1.0	0.0	5.6	0.0	- -	- -
nearly every day	0.2	1.6	0.0	0.0	- -	0.0	0.2	0.3	0.0	0.0	0.0	- -	- -
at least daily	0.1	0.0	0.0	0.0	- -	0.0	0.1	0.3	0.0	0.0	0.0	- -	- -
Crystal Meth (2002 Survey)													
Not used in yr	82.5	87.1	66.0	73.0	60.0	62.5	74.5	63.4	93.1	75.0	- -	72.2	70.4
Not used in last six months	3.7	6.5	0.0	8.1	6.2	6.3	2.0	12.2	1.4	0.0	- -	22.2	3.7
Used in last 6 months	5.3	3.2	12.8	5.4	16.9	10.4	3.9	7.3	2.8	0.0	- -	0.0	12.3
Used less than once a month	2.0	3.2	4.3	0.0	3.1	4.2	5.9	2.4	1.4	0.0	- -	0.0	3.7
Used at least once a month	3.3	0.0	8.5	10.8	3.1	8.3	11.8	7.3	0.0	25.0	- -	5.6	4.9
Used once a week or more	3.3	0.0	8.5	2.7	10.8	8.3	2.0	7.3	1.4	0.0	- -	0.0	4.9
Crystal (glass or ice), Speed, Uppers (APLA)													
never used	86.8	86.6	82.5	89.5	- -	68.1	89.8	83.0	98.0	81.0	80.0	- -	- -
once a month	6.6	5.5	8.7	5.9	- -	11.6	5.6	8.0	1.0	14.3	0.0	- -	- -
2 or 3 times a month	3.4	3.9	4.5	2.6	- -	8.7	2.8	3.8	0.0	0.0	20.0	- -	- -
1 or 2 times a month	2.2	3.9	2.6	1.6	- -	10.1	1.3	3.8	0.0	4.8	0.0	- -	- -
nearly every day	0.9	0.0	1.5	0.3	- -	1.4	0.4	1.3	1.0	0.0	0.0	- -	- -
at least daily	0.1	0.0	0.2	0.0	- -	0.0	0.0	0.0	0.0	0.0	0.0	- -	- -

Attachment 12 Special Population Comparative Data Table													
	Total	MSM	MSM	MSM		Hx of	NON-	REC					Severe
	Sample	Af Am	Anglo	Latino	IDU	Hmls	IDU	INC	WCB	TG	Youth	Undoc	MH
OAPP Client Database (N)	**19149**	**1680**	**2875**	**2819**	**1268**	**1850**	**- -**	**- -**	**3096**	**191**	**244**	**- -**	**- -**
APLA (N)	**1365**	**137**	**557**	**333**	**- -**	**76**	**1179**	**329**	**107**	**25**	**11**	**- -**	**- -**
2002 Survey (N)	**246**	**31**	**47**	**37**	**65**	**48**	**51**	**41**	**72**	**4**	**- -**	**18**	**81**
SHAS (N)	**533**	**70**	**51**	**141**	**104**	**51**	**241**	**198**	**- -**	**- -**	**- -**	**- -**	**- -**
LAC-USC 5P21 (N)	**- -**	**250**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**
Transgender Study (N)	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**- -**	**54**	**- -**	**- -**	**- -**
	%	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Speed (2002 Survey)													
Not used in yr	92.7	93.5	91.5	89.2	84.6	89.6	92.2	87.8	95.8	100.0	- -	77.8	87.7
Not used in last six months	4.5	6.5	4.3	8.1	9.2	8.3	2.0	12.2	2.8	0.0	- -	22.2	7.4
Used in last 6 months	1.6	0.0	2.1	0.0	4.6	0.0	2.0	0.0	0.0	0.0	- -	0.0	3.7
Used less than once a month	0.4	0.0	0.0	0.0	0.0	0.0	2.0	0.0	1.4	0.0	- -	0.0	0.0
Used at least once a month	0.4	0.0	2.1	0.0	0.0	0.0	2.0	0.0	0.0	0.0	- -	0.0	0.0
Used once a week or more	0.4	0.0	0.0	2.7	1.5	2.1	0.0	0.0	0.0	0.0	- -	0.0	1.2
GHB (2002 Survey)													
Not used in yr	93.5	93.5	91.5	91.9	86.2	93.8	94.1	87.8	95.8	100.0	- -	77.8	90.1
Not used in last six months	4.1	6.5	2.1	8.1	7.7	6.3	2.0	9.8	2.8	0.0	- -	22.2	6.2
Used in last 6 months	1.2	0.0	4.3	0.0	3.1	0.0	2.0	2.4	0.0	0.0	- -	0.0	2.5
Used less than once a month	0.8	0.0	2.1	0.0	1.5	0.0	2.0	0.0	1.4	0.0	- -	0.0	0.0
Used once a week or more	0.4	0.0	0.0	0.0	1.5	0.0	0.0	0.0	0.0	0.0	- -	0.0	1.2
GHB (APLA)													
never used	97.2	99.2	94.1	99.0	- -	96.9	98.0	97.4	100.0	100.0	100.0	- -	- -
once a month	2.3	0.8	4.6	1.0	- -	1.5	1.5	2.0	0.0	0.0	0.0	- -	- -
2 or 3 times a month	0.3	0.0	0.8	0.0	- -	0.0	0.3	0.3	0.0	0.0	0.0	- -	- -
1 or 2 times a month	0.1	0.0	0.2	0.0	- -	1.5	0.0	0.0	0.0	0.0	0.0	- -	- -
nearly every day	0.2	0.0	0.4	0.0	- -	0.0	0.2	0.3	0.0	0.0	0.0	- -	- -
Poppers (2002 Survey)													
Not used in yr	87.0	87.1	70.2	86.5	73.8	81.3	78.4	75.6	95.8	100.0	- -	77.8	81.5
Not used in last six months	4.1	3.2	2.1	8.1	9.2	8.3	0.0	9.8	2.8	0.0	- -	22.2	6.2
Used in last 6 months	3.3	3.2	4.3	5.4	7.7	4.2	5.9	4.9	0.0	0.0	- -	0.0	7.4
Used less than once a month	3.7	3.2	14.9	0.0	6.2	2.1	9.8	4.9	1.4	0.0	- -	0.0	2.5
Used at least once a month	1.2	3.2	4.3	0.0	1.5	4.2	3.9	4.9	0.0	0.0	- -	0.0	2.5
Used once a week or more	0.8	0.0	4.3	0.0	1.5	0.0	2.0	0.0	0.0	0.0	- -	0.0	0.0
Poppers (APLA)													
never used	81.9	86.4	74.3	84.6	- -	72.5	82.6	80.9	100.0	89.5	90.0	- -	- -
once a month	10.3	7.2	14.9	9.1	- -	8.7	10.2	12.3	0.0	5.3	10.0	- -	- -
2 or 3 times a month	4.2	4.8	6.0	2.7	- -	11.6	3.8	4.9	0.0	0.0	0.0	- -	- -
1 or 2 times a month	3.3	1.6	4.2	3.7	- -	5.8	3.0	1.3	0.0	5.3	0.0	- -	- -
nearly every day	0.2	0.0	0.6	0.0	- -	0.0	0.3	0.3	0.0	0.0	0.0	- -	- -
at least daily	0.1	0.0	0.0	0.0	- -	1.4	0.1	0.3	0.0	0.0	0.0	- -	- -
Ecstasy (2002 Survey)													
Not used in yr	91.5	90.3	83.0	91.9	83.1	91.7	88.2	85.4	95.8	100.0	- -	77.8	88.9
Not used in last six months	4.5	6.5	4.3	8.1	9.2	8.3	2.0	12.2	2.8	0.0	- -	22.2	7.4
Used in last 6 months	1.2	3.2	2.1	0.0	1.5	0.0	3.9	0.0	0.0	0.0	- -	0.0	1.2
Used less than once a month	1.6	0.0	6.4	0.0	3.1	0.0	3.9	2.4	1.4	0.0	- -	0.0	1.2
Used at least once a month	0.4	0.0	2.1	0.0	1.5	0.0	0.0	0.0	0.0	0.0	- -	0.0	0.0
Used once a week or more	0.8	0.0	2.1	0.0	1.5	0.0	2.0	0.0	0.0	0.0	- -	0.0	1.2
Ecstasy (APLA)													
never used	96.8	96.8	94.1	98.7	- -	92.6	97.2	97.1	100.0	100.0	90.0	- -	- -
once a month	2.6	3.2	4.6	1.0	- -	4.4	2.2	2.6	0.0	0.0	0.0	- -	- -
2 or 3 times a month	0.6	0.0	1.1	0.3	- -	2.9	0.4	0.3	0.0	0.0	10.0	- -	- -
1 or 2 times a month	0.1	0.0	0.2	0.0	- -	0.0	0.1	0.0	0.0	0.0	0.0	- -	- -
Injected substance history (2002 Survey)	22.8	16.1	40.4	5.4	86.2	43.8	0.0	41.5	11.1	25.0	- -	5.6	37.0
Injected in last six months (APLA)	5.0	4.6	6.1	4.0	- -	17.1	0.0	8.7	0.0	13.6	9.1	- -	- -
Ever injected a drug w/ a needle (SHAS)	21.3	27.0	20.0	13.8	100.0	45.7	29.7	33.0	- -	- -	- -	- -	- -
Ever injected a drug w/ a needle (LAC-USC 5P21)	- -	17.6	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -	- -

Attachment 13 HIV/AIDS Interface Technology System (HITS) Project Description

Description of the Intervention: OAPP is proposing to adapt its current and developing technology with three client tracking and eligibility screening interfaces in order to (1) eliminate the proportion of Los Angeles County residents who test HIV+, but do not return for their results, (2) mitigate the delays between testing HIV+ and entering an HIV system of care, and (3) improve local ability to appropriately screen clients for service eligibility, therein maximizing of Federal resources of last resort. The new Continuum of Care model adopted by the CHHS and the PPC describes a seamless system of care for people with and at risk for HIV/AIDS anchored by a primary healthcare services core, with several points of entry, including HIV counseling and testing (HCT) and early intervention services.

The new Continuum of Care parallels the intent of the reauthorized Ryan White CARE Act legislation by stipulating a system of care in which people at risk of HIV receive preventive services and are moved swiftly into a system of care if, and when, they are infected with HIV. Consistent with the CARE Act, the new Continuum of Care emphasizes "points of entry" as key to the service continuum, and defines newly diagnosed individuals and people who have not accessed care services as among the priority populations with unmet need.

Los Angeles County has developed a complex and effective system of care for people at risk of or living with HIV/AIDS. The system includes two predominant service categories: prevention services (includes health education, risk reduction and HCT services), and care and treatment services. The success of the system and Los Angeles County's capacity to develop a seamless approach to care hinges on the ability to effectively bridge the two predominant service categories: for example, ensuring that people testing HIV+ are effectively and promptly linked to care and treatment. Additionally, the system's success depends on each step along the continuum maximizing its impact (e.g., ensuring that clients testing for HIV return for their results).

HIV Information Resources System (HIRS): OAPP is currently in the midst of developing its own web-enabled, integrated data and technology system, HIRS. OAPP's HITS project offers Los Angeles County an important opportunity to develop several electronic inter-faces which will enhance and expand on HIRS. The proposed interfaces will be designed to ensure that the post-test return rate for persons testing HIV+ is maximized, that all persons testing HIV+ are effectively linked into care, and that mandated eligibility screening for people seeking CARE Act-funded services has effected the maximum use of alternate payor sources (such as MediCal, Medicaid, private insurance and VA benefits). HIRS will enable OAPP to track client-, contract- and service-, provider-level service delivery, program progress, management information and fiscal data. It will also improve OAPP's and providers' ability to more effectively and efficiently track and report HIV service delivery, its impact and its costs.

HIRS is a set of computer application systems and technologies that include the OAPP Extranet (wide-area networking) infrastructure, integrated databases, and application

system modules that support the operational and managerial information necessary for OAPP's core business, data collection and data reporting needs. HIRS will eventually manage all data collection, technological and information resources of OAPP's HIV/AIDS prevention, care and treatment systems, internally and externally. The HIRS framework and process flow has been designed, and programming work for each of its component modules has begun. Given the incongruent and/or inadequate nature of OAPP's prevention services data collection, tracking and reporting systems, the HIV Prevention Information System (HPIS) module is the first HIRS component application scheduled for completion. It is expected to be on-line and operational by December 2002.

HPIS will produce various types of reports and information; track and maintain detailed (client- and encounter-level) information on demographics, behavioral risk factors, HIV test results, targeted population groups, BRGs, high-risk cohorts, and services. It will capture and manage prevention data required for case management and monitoring that supports provider responsibilities; and enable other prevention-related functions. HPIS will replace or automatically interface with/export to (when use of a specific reporting systems are required by funding sources) several prevention data tracking and reporting systems that lack standardization and intra-translation capacity. HPIS is essential to HITS' goals as it will interface with IMACS/ Casewatch (the care services data system) to facilitate movement of seropositive HCT clients into the care services continuum. Ultimately, HIRS will be designed to automatically interface with IMACS/Casewatch or replace that system altogether. That determination will be made as the HIRS care services system is developed over the next two to three years, and will be based on functionality, flexibility and cost-effectiveness criteria. Slow implementation of HIRS is necessary, though, due to limited financial.

The proposed adaptations to the HIRS technology will not only yield significant health, service delivery, quality of care and cost-effectiveness outcomes detailed in this proposal, but will lay the groundwork for important technological innovations to Los Angeles County's HIV/AIDS system of care including, but not limited to:

- Automatic and online referral across multiple sites;
- Electronic-mail messaging between HIV/AIDS service delivery staff including certified HIV counselors, case managers, and other prevention, care services and treatment personnel in the network of OAPP-funded providers;
- Automatic referral scheduling across service delivery sites;
- System-wide access to client records; and
- Cross referencing of CARE Act service eligibility status to agency payment and invoicing information.

Problem Statement/Areas of Improvement: OAPP has identified three areas that will benefit from the effective implementation of the proposed HITS Project. They are (1) improvement in return rates for persons testing HIV+, (2) successful linkage of HIV+ HCT clients to an appropriate primary healthcare delivery system, and (3) electronically integrated client eligibility screening to maximize use of alternate sources of service support and systems of care.

Project Plan: HCT is a critical service at the intersection of Los Angeles County's HIV prevention and care service systems. Los Angeles County has recently implemented fee-for-service reimbursing HCT providers that target persons most at risk for HIV infection. The new reimbursement system provides incentives to providers to target high risk behavior groups and pays providers for each step in the HCT process, including risk assessment, disclosure and/or partner notification services, and other interventions. Resources are allocated based on a methodology adopted by the Los Angeles County HIV Prevention Planning Committee (de-scribed in the accompanying HIV Prevention Plan 2000). The methodology identifies six BRGs and two-set aside groups as most in need of HIV prevention services, including HCT services. The BRGs are men who have sex with men (MSM), men who have sex with men and women (MSMW), men who have sex with men and who inject drugs (MSM/IDU), female injection drug users (FIDU), men who have sex with women and who inject drugs (MSW/IDU), and women at sexual risk (WSR), and the two set-aside groups are transgender and Native Americans. While OAPP-funded HCT services are targeted to those eight populations, HCT services are also available to those outside the targeted groups. This fee-for-service provider reimbursement for-mat will be utilized in the process of developing baseline data for cost-effectiveness measurement and evaluation.

HIV Status Follow-up System (HSFUS) Interface: Given the volume of HCT services delivered annually in Los Angeles County (nearly 90,000 HIV tests) and the corresponding investment in services, HCT providers are encouraged (through the financial incentives established by a fee-for-service system) to test persons who are most at risk, and to develop internal infrastructures ensuring that clients benefit from all HCT interventions—especially returning for their test results. While OAPP has creatively developed a reimbursement system which favors maximized client-testing rates, the return rate for people testing HIV+ is 76%, which falls short of the Federally-established goal of 90%.

In response, OAPP is proposing the development of an electronic client tracking system (designed as a HIRS interface) for use by all OAPP-funded HCT providers to inform them of the number and locator information of HCT confidential clients testing HIV+ who have not returned for their results. HSFUS will enable HIV counselors to actively follow-up with clients and encourage their return for a disclosure session. Though client follow-up will be limited to clients who test confidentially, OAPP is committed to ensuring that all certified HIV counselors are aware of the benefits of confidential testing, are trained to encourage their clients to do so, and impart this information to their clients. Anonymous testing is an important component of the local HIV service delivery system, and will continue making anonymous testing available. However, anecdotal evidence suggests that clients who trust and are comfortable with their HIV counselors are often more inclined to test confidentially, especially with the promise of available services. HSFUS will enable HCT providers to routinely follow up with clients and prompt them to return for their results. The new fee-for-service system makes it a financial incentive (through a significantly higher reimbursement rate for HIV+ clients who return for their results) for HCT providers to invest the staff time and resources in these follow-up

activities. The HSFUS interface will provide them with the tools and resources to carry out these efforts effectively.

HIV Referral Follow-Up System (HRFUS) Interface: As is most large urban settings, Los Angeles County is challenged by facilitating the completion of client-centered referrals across multiple service providers. The new Continuum of Care envisions a seamless healthcare delivery system that enhances client access to care. By adapting its HIRS technology, HITS will incorporate a second interface, HRFUS, to help ensure that clients who test HIV+ are immediately referred to appropriate HIV services delivery, and do not fall out of the system. OAPP estimates that a significant fraction of persons testing HIV+ fail to access medical care within a year of learning their status. An even higher proportion fail to access medical care within six months of learning their status. These delays of entry into care contribute significantly to expensive mid- and late-stage disease treatment costs, may accelerate HIV transmission in the absence of secondary HIV prevention messages, and may erode the client's quality of life in the absence of vital early intervention efforts.

To mitigate the proportion of people testing positive who are not effectively linked to care, OAPP will design a system that elicits basic client level information to provide targeted medical care and social service referrals at the completion of the counseling and testing disclosure session. This information will generate specific, client-centered referrals tailored to their specific geographic, cultural and service needs. The HRFUS Interface will notify care service providers of these referrals, and can provide real-time linkages via the use of client identifiers. With the intervention of the HRFUS Interface, care service providers can confirm the client's access of services, and the referring agency can document referral completion. Conversely, HRFUS will also enable the referring and referral agencies to follow-up at defined intervals (e.g., weekly, monthly) with clients have entered the HIV system of care. HRFUS will reduce the delay from the time a client learns his/her HIV status to accessing primary healthcare and ancillary services.

OAPP currently uses the IMACS/Casewatch system for a number of its client- and encounter-level data tracking and reporting needs. HITS will entail the adaptation of that technology into HIRS through the HRSUS Interface. Adapting these existing technologies to local needs will result in an integrated platform that transitions newly diagnosed seropositive clients into primary HIV/AIDS healthcare.

CARE Act Service Eligibility System (CASES) Interface: The final proposed system interface comprised in HITS is CASES, an electronically enhanced IMACS/Casewatch client eligibility screening module that will enable Los Angeles County's HIV service providers to determine service eligibility of all new clients entering the system. Without proper standardization of eligibility screening nor the data systems to support it, a portion of CARE Act clients do not fully avail themselves—nor are they helped in doing so—of services through other, primary payor sources (e.g., Medi-Cal, Medicaid, VA, ADAP, and private insurance. CASES will enable all local CARE Act-funded service providers to quickly assess client eligibility for services, make appropriate referrals as needed, and

improve the local capacity to maximize federal HIV/AIDS resources of last resort. Service needs have increased exponentially due to increased service complexity, decreased mortality, and new infections—outpacing CARE Act funding increases to the EMA.

The integrated framework of HIRS provides the platform for CASES to close the gap between prevention and care services. Eligibility screening will begin in the HCT post-test counseling session, and will be verified and completed in the intake process to care services. Referrals will be tailored to maximize resources and targeted to client needs. Limited financial information in CASES fields can help the HCT provider direct them to the appropriate system of care before they leave the counseling session—therein mitigating a common barrier to care. CASES' eligibility screening will interface with the AIDS Resource Director to ensure that clients are referred to appropriate providers inside and outside the CARE Act service delivery system. It is expected that by the conclusion of the project duration, HIRS will be automatically linking eligibility screening in the HCT environment to the care services environment.

Outcomes: The proposed HSFUS, HRFUS and CASES Interfaces will improve outcomes in all three areas of emphasis of this initiative: service delivery, quality control and cost effectiveness. The Project Evaluator and team will define specific, numerical and percentage outcome objectives within the first nine months of project start-up, after establishing baseline data comparisons.

Service Delivery *(Optimizing the delivery of HIV care)*:

1) More HIV+ individuals will learn their status and enter the HIV system of care;
2) More HIV+ individuals will enter the HIV system of care with less delay;
3) Understanding of the demographic and behavioral factors which impede access to care will be substantially enhanced; and
4) Higher proportions of individuals will test confidentially due to improved patient education.

Quality of Care/Clinical Issues *(Optimizing outcomes and quality of HIV care):*

1) Improved access to care will ensure better early intervention and primary healthcare responses for newly diagnosed seropositive clients;
2) Cross-referral of clients from HCT to primary healthcare and other support services will result in heightened quality of care; and
3) Expediting immediate entry into care after HIV diagnosis will delay disease progression and onset of HIV/AIDS illnesses;

Cost Effectiveness *(assessing the cost-effectiveness of the intervention):*

1) Increased identification of HIV+ persons will improve the effectiveness HIV prevention efforts, mitigate HIV transmission, and ultimately eliminate care costs;
2) Preventing the onset of HIV/AIDS symptoms (secondary prevention) due to early intervention will reduce costly mid and –late- stage medical care costs; improving

HCT return rates will reduce the need for multiple HCT interventions and maximize the initial testing investment; and

3) Consistent identification other sources of payment for eligible care clients will ensure that CARE Act resources are more effectively used as funds of last resort.

Service Settings: Currently all OAPP-funded care and treatment provider sites are contractually required to manage and track client records and services, and report the data electronically on either of two electronic platforms: IMACS (Information Management of AIDS Cases and Services) or Casewatch (an upgraded, Windows-platform, version of IMACS). Consequently, every care service provider site has access to the technology fundamental to HITS. In addition, all OAPP-funded HCT providers use the State of California issued HIV-5 client assessment form used for data tracking and reporting purposes. HIRS will replace the current HIV-5 system. Ultimately, the linkages and integration components HITS entails will be contractually-mandated at all OAPP-funded service delivery sites. To this end, OAPP anticipates that all existing and future OAPP-contracted providers delivering HCT and/or care and treatment ser-vices will serve as service settings for the these technology adaptations.

User Groups: The proposed adaptations of current and future technology applications will affect OAPP-funded providers most directly. Providers are the user groups required to implement these new technological applications, with new reporting, tracking and intake adaptations. While clients—namely those who are newly diagnosed and/or accessing care services for the first time—will benefit from the innovations, they will not use the system(s) directly.

Roles and Responsibilities of Involved Organizations: OAPP is the lead applicant organization, and will coordinate and manage all project activities. As the lead, OAPP's primary responsibilities include project organization, system design and integration and project evaluation. All other HITS partners are vendors or contracted agencies. The two principle partners are ACMS and APLA. All contracted providers will be required to execute project activities during the course of project implementation.
ACMS is the owner and technical advisor for IMACS/Casewatch. OAPP has worked with ACMS for close to a decade developing and integrating the IMACS/Casewatch system into the Los Angeles County HIV/AIDS service delivery network. ACMS will assist OAPP in the adaptation of the current intake system, and adoption and adaptation of CASES. They will serve as technical advisors to HITS, helping OAPP design, test, evaluate and implement the new system designs at HCT and care service sites *(an abbreviated copy of the ACMS contract with OAPP is attached as Appendix D.1)*.
This past year, OAPP began contracting with APLA to develop and maintain a web-enabled AIDS Resource Directory for Los Angeles County. The Directory will be available to all providers, and will include both CARE Act- and non-CARE Act-funded resources. The Directory is expected to be on-line prior to the implementation phase of HITS. The Project Coordinator will serve as the lead project liaison between the contract's OAPP program manager, the project team, and APLA staff to ensure proper, on-going maintenance of the Directory and its subsequent adaptations in accordance with HITS goals and objectives.

HCT and care services providers also play a pivotal role in the successful implementation of HITS. OAPP maintains contractual relationships with more than 100 HIV/AIDS service providers. Currently, all providers are required to submit monthly data reports in accordance with OAPP's existing information technology platforms. As HITS evolves, the currently required intake, data reporting and referral requirements will be modified and incorporated into the con-tracts accordingly. It is expected that full project implementation will be a contractual requirement of all care service and HHCT providers by March 2004 (Title I Year 14). In addition, several sites will test-pilot HITS prior to implementation, and staff from various providers will be asked to provide community provider feedback, input and advice.

CONCEPT PAPER: SERVICE PROVIDER NETWORKS

Draft 2: Planning and Development Division Work Group (October 10, 2001)

The Office of AIDS Programs and Policy
The Los Angeles County Department of Heath Services
and
The Los Angeles County HIV/AIDS Strategic Planning Process

This document is produced for discussion purposes only. It is under revision now, it will continue to be under revision. Every concept, every idea is subject to revision. The document is not approved and therefore is not prepared for public distribution.

INTRODUCTION

The Planning and Development Division (P&D) of The Office of AIDS Policy and Programs (OAPP) is seeking assistance from community service providers (AIDS service organizations, public and private community health and social services providers, larger health provider institutions, etc.) who are interested in practical, problem-solving activities related to HIV/AIDS prevention and care/treatment services development and implementation.

P&D/OAPP is convening SPA-based groups of providers for the purpose of discussing how to better serve communities and populations, how to define a "mix of services" to better meet the diverse needs of communities and populations, how to build capacity among providers for prevention, care and treatment, and how to continually improve the quality of services made available to consumers in LAC communities.

REASONS FOR SERVICE PROVIDER NETWORKS

OAPP is committed to the Strategic Planning Process directive to implement Community Relevant and Community Responsive HIV Services Planning, and is convening the Service Provider Networks as one group of stakeholders who are critical to fulfilling this approach to planning.

In addition, OAPP will now play its part in managing the new HIV/AIDS Continuum of Care, evolving from the Strategic Planning Process, and recently approved by the LAC HIV/AIDS Commission on Health Services. Service Provider Networks will assist OAPP in "making the Continuum real." The OAPP and SPNs will establish formal, on-going and mutual relationships to discuss the practical issues involved in managing service delivery within this Continuum.

Finally, OAPP is committed to the Strategic Planning Process directive to relate current research and policy to community practice. Service Provider Networks will be a vehicle through which OAPP will review and discuss [services] research and the applied policy implications for LAC's diverse communities and populations of service.

THE OAPP ROLES AND RESPONSIBILITIES

OAPP has legislated roles and responsibilities for the disbursement of grant (and other source) funds, for assuring the financial management of those funds and maintaining stewardship over the use of those funds. OAPP is ultimately responsible for assuring the quality and consistency of services procured through these funds. OAPP is not altering its role and responsibility for the management, stewardship or quality of services.

The "change" implied by establishing Service Provider Networks is a further enhancement and elaboration of the relationship between OAPP and providers defined through service contracts and agreements. And, it is a further enhancement and elaboration of OAPP's public health responsibilities related to quality services delivery for diverse communities and county residents.

OAPP is strengthening its relationships with providers (funded and unfunded by OAPP) through the Service Provider Network approach to improve OAPP's procurement of services, making them more relevant and responsive for communities and populations, and to improve OAPP's identification of strategies and support systems for continuously improving the quality of services for all communities and populations.

OAPP needs practical, relevant and quality methods for the delivery of services. OAPP cannot meet this need outside of consistent and directed discussions with service providers. However, OAPP retains the final authority for maintaining standards of care for all service, for writing and releasing Requests for Proposals to procure services, for assessing program and provider compliance with the HIV/AIDS Continuum of Care, and for managing contracted relationships with providers.

In summary, OAPP will retain its role and responsibility for managing the overall health outcomes for HIV-infected and at risk populations and for managing the effectiveness and efficiency of the HIV-related health service delivery system. Service Provider Networks will assist and facilitate OAPP in meeting these roles and responsibilities.

WHO IS A SERVICE PROVIDER NETWORK MEMBER?

OAPP has recently contracted Service Provider Networks in both prevention and care and treatment. [Describe the current funded networks here.]

These contracted networks are viewed as opportunities [not pre-sanctioned, exclusive groups] for beginning the Service Provider Network functions related to the Strategic Planning Process. OAPP will add individuals, community representatives, and providers as needed (and as recommended) in order to take full advantage of any and all perspectives and points of view. This will include individuals, community representatives and providers who are funded by OAPP-disbursed HIV/AIDS funding (both prevention and care and treatment funds) as well as those who are not funded by OAPP.

A provider's participation in Service Provider Network activities will be based on the ability to contribute to the service delivery issue being addressed. Participation will be needed from agencies of every size, of every stage of organizational development, and from agencies serving diverse populations across the County. In some cases, providers may well be asked to participate in more than one Service Provider Network. This will particularly be the case when a provider agency serves clients from more than one SPA.

WHAT IS SERVICE PROVIDER NETWORK?

Service Provider Networks are SPA-based, formally organized groups of providers convened to assist OAPP in service system development. The Service Provider Networks will be used to promote consistent perspectives and recommendations from providers to OAPP on service system changes and improvements. These service system changes are related to the coordination of services, service category definitions and requirements, and standards for services.

The Service Provider Networks will not duplicate RWCA or CDC planning body functions, nor will they duplicate existing community health planning and advisory groups currently active in the SPAs. The discussions of the SPNs will be informed by the needs assessments, comprehensive care plans and other planning recommendations from these planning bodies. However, the Service Provider Networks are specifically related to OAPP's legislated role and responsibility for managing the actual service delivery providers contracted through the RWCA and CDC prevention and care/treatment programs.

The Service Provider Networks will not directly control nor influence the

OAPP's role and responsibility for the disbursement of grant (or other) funds used to support the service delivery system. OAPP will retain its role of providing stewardship for the use of grant (and other source) funds and will retain its responsibility for financial management of the grant-making program.

The Service Provider Networks are intended to facilitate an improved coordination of care, using the HIV/AIDS Continuum of Care as an overall standard. They are not intended to become tightly and exclusively defined groups of providers that increase competition for already limited financial and other resources. Service Provider Networks will assist OAPP in identifying and resolving practical problems that are impeding coordination in the service continuum. The work of the SPNs is directly related to four goals:

.Provision of quality, state of the art services
.Increasing and sustaining access for vulnerable populations
.Documenting improved health outcomes
.Eliminating health outcome disparities for racial and ethnic minorities

WHAT'S THE AGENDA? (NOT LISTED IN ANY PRIORITY ORDER.)

1. The Strategic Planning *Framework* identifies "Four Critical Participants" that are necessary to fulfilling the directives from the strategic planning process (See also the "Seven Lenses"). One of the critical participants is "Experienced, Vigilant Providers," and OAPP and its contracted providers are challenged to fulfill the expectations implied in this concept. The concept needs full discussion (definition, how to implement, and evaluation criteria) and providers are one voice in this discussion.

2. The strategic planning process will soon initiate planning discussions on four (4) new Needs Assessments in four SPAs. The needs assessment and planning process is committed to a more community responsive, community relevant approach to assessing needs and to planning service systems to meet these needs. The providers are one voice in shaping this new needs assessment process.

3. The LAC HIV/AIDS Commission on Health Services recently approved an HIV/AIDS Continuum of Care model for use in improving community services. Providers are one voice in identifying the general issues and concerns related to the new Continuum of Care, identifying the training and capacity-building needs among providers required to support full implementation of the Continuum, and identifying and resolving barriers to full implementation.

4. There is very practical work related to implementing the continuum of care:

comprehensive and shared assessment tools and treatment planning tools must be developed, linkage and coordination agreements must be developed, terms and conditions for participation in the Continuum of Care must be developed, and many providers will need actual Service Delivery Protocols and Standards of Care in order to assure a consistent implementation of services. Providers are one voice in developing this list of practical tools.

5. Others...

Attachment 15 Framework For Future Priority and Allocation-Setting

Presented by
Marc Haupert, Commission Member
Priorities and Planning (P&P) Committee

There are a number of challenges facing the Commission in effectively determining priorities and allocations.

Challenge #1: When priorities and allocations are determined in June/July, the administrative agency cannot make significant changes until the following year *(due to the length of time required by the County's service procurement process)*. OAPP begins contract development in September for implementation the following March—precluding a new RFP/solicitation process, if needed.
Challenge #2: Based on this year's experience getting POs approved, a full year would require for the solicitation and selection of firms by September 2002.
Challenge #3: This year's delays resulted in an abbreviated process, and two of the processes have not yet begun: financial needs assessment and budgeting.

In developing the ongoing needs assessment and priorities and allocation process the P&P Committee is confronted with a number of realities:

Reality #1: The Commission will not be ready to begin another needs assessment process immediately, before this year's needs assessment process has been fully concluded. Reality #2: The Commission's priority- and allocation-setting process must be moved to earlier in the year for it to impact the subsequent year's service procurement process. The priority- and allocation-setting process should be concluded by March if order for the administrative agency to fully engage that process (e.g., RFPs, solicitation, contracting, etc.), if needed. Reality #3: If the Commission moves its priority- and allocation-setting process up several months, there is going to be one year in which the Commission will not be able to conduct a full needs assessment process.
Reality #4: HRSA does not require the EMA to conduct a new needs assessment annually, nor does it require the EMA to determine all new priorities and allocations every year.

Reality #5: Consumer forums are not only essential to the needs assessment, but also represent the Commission's primary vehicle for client input, and, as such, must be conducted annually. Consumer forums must occur much earlier in the year, with much more preparation and provider training in order to be effectively used for future processes.
Reality #6: The Commission, and its P&P Committee, should be devoting more of its time to the implementation of the Continuum of Care and comprehensive care planning. Both efforts require more time than the Committee and the Commission have been able to dedicate to them.
Reality #7: If there is a year in which to make changes, this is the year:

- The EMA is implementing a new Continuum of Care, which requires a lot of work and encompasses an extended needs assessment process.
- The Commission has already set in motion the process to conclude a full needs assessment—service needs assessment *(done)*, and financial needs assessment *(pending)*.

The solutions (passed by the Commission) include:

1. Advance Year 14 priority- and allocation-setting from June/July 2003 to February/March 2003. As a result, the Commission will not be able to conduct a full, completely new needs assessment for the Year 14 priority- and allocation-setting process.
2. Once the Year 14 priority and allocation-setting process is concluded in March 2003, the P&P Committee will immediately initiate the solicitation/selection of the Year 15 needs assessment consultants.This will give the Commission enough time to con- duct a full needs assessment for the following year.
   2.2. This will be the needs assessment cycle for subsequent years.The Commission will be able to solicit for "2nd Generation" needs assessments per strategic planning.
3. Rather than conducting a new needs assessment for Year 14 priority- and allocation-setting, the Commission will update and refine its Year 13 priorities and allocations. The P&P Committee will update Year 13 priori-ties and allocations for Year 14 with information generated by the financial needs assessment. The P&P Committee will refine Year 13 priori-ties and allocations for Year 14 with SPA-based and subpopulation-based data/information.
4. With less time devoted to priority and allocation-setting in the next six months, the P&P Committee will devote its attention to other important activities:Completing the revisions of the Comprehensive Care Plan and developing strategies to educate the community about it.
   4.2. Working with the administrative agency to implement the new Continuum of Care.
5. The P&P Committee will con-duct consumer forums from December 2002 – January 2003. The process to select a consumer forum coordination consultant and to train providers will begin in September 2002.
6. The P&P Committee will begin on-going, continuous data collection and analysis, rather than a one-time a year effort. Continuous data collection is a primary needs assessment recommendation from the LA County HIV/AIDS Strategic Planning Process.

Attachment 16 HIV Epi Estimates of AIDS Incidence and AIDS and HIV Prevalence

	AIDS INCIDENCE	2000-2001	AIDS PREVALENCE AS OF 12/31/01		HIV (NOT AIDS) PREVALENCE AS OF 12/31/01	
			AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.		HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.	
Race/Ethnicity	**Number**	**%**	**Number**	**% of Total**	**Number**	**% of Total**
Anglo	718	28.3	6381	38.6	5106	19.3
African American	631	24.9	3573	21.6	8218	31.1
Hispanic / Latino	1111	43.8	6091	36.8	11,640	44.0
Asian/Pacific Islander	62	2.4	381	2.3	786	3.0
American Indian/Alaska Nat	10	0.4	67	0.4	291	1.1
Not Specified	3	0.1	43	0.3	417	1.6
Total	**2535**		**16536**		**26458**	100.0
Gender	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Male	2185	86.2	14841	89.7	22648	85.6
Female	350	13.8	1695	10.3	3810	14.4
Total	**2535**		**16536**		**26458**	
Age at Diagnosis (Years)	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
<13 years	7	0.3	75	0.5	182	0.7
13-19 years	16	0.6	103	0.6	794	3.0
20-44 years	1807	71.3	13365	80.8	22333	84.4
45+ years	705	27.8	2993	18.1	3149	11.9
Total	**2535**		**16536**		**26458**	100.0
Adult/Adolescent AIDS Exposure Category	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
MSM	1657	65.5	11942	72.6	17236	65.6
Injection drug users	297	11.7	1507	9.2	3074	11.7
MSM and injection drug users	155	6.1	1025	6.2	1603	6.1
Heterosexuals	390	15.4	1767	10.7	4073	15.5
Other/hemophilia/blood transfusion	29	1.1	219	1.3	289	1.1
Risk not reported or identified	0*	*redistributed	0*	*redistributed	0	0
Total	**2528**	**100.0**	**16460**	**100.0**	**26275**	**100.0**
Pediatric AIDS Exposure Categories	**#**	**% of Total**	**#**	**% of Total**	**#****	**% of Total**
Mother with/at risk for HIV infection	6	85.7	62	81.6	148	80.9
Other/hemophilia/blood transfusion	0	0	13	17.1	31	16.9
Risk not reported or identified	1	14.3	1	1.3	4	2.2
Total	**7**	**100.0**	**76**	**100.0**	**183**	**100.0**

*NIR redistributed according to NIR reclassification pattern in the last 5 years (see table below).
** Actual data from Pediatric AIDS.

	PLWA	NIR redist	total	%		incidence	NIR redist	total	%
MSM	10804	1138	11942	72.5	MSM	1319	338	1657	65.5
IDU	1234	273	1507	9.2	IDU	216	81	297	11.7
MSM/IDU	899	126	1025	6.2	MSM/IDU	117	38	155	6.1
Hetero	1181	586	1767	10.7	Hetero	216	174	390	15.4
Other	179	42	221	1.3	Other	17	13	30	1.2
nir	2165	2165	16462	100.0	nir	643	643	2528	100.0

PLWAs	16,536	**(HARS)**
PLWH (non-AIDS, diagnosed)	26,458	**HEP estimate**
PLWHA (diagnosed)	42,994	**for HRSA**
PLWH (undiagnosed)	8,819	**from MMWR**
PLWHA (est incl undxed)	**52,000**	**for Planning**
estimate range	**43,000 - 61,000**	

Attachment 17 Community Advisory Boards and Consumer Involvement

Community Advisory Boards (CABs) and Consumer Involvement

Since the inception of Ryan White CARE Act legislation in 1990, consumer involvement, input and direction has been a pivotal factor in local EMA HIV/AIDS care services planning. The CARE Act FY 2000 reauthorization further strengthened the role of consumers in the EMA planning processes. As a result, it is imperative that the Los Angeles County EMA develop strategies to improve and institutionalize consumer involvement and participation in HIV/AIDS planning.

The EMA has already taken several key steps in that direction:

1. In 1999, OAPP began contractually requiring service providers to establish "Community Advisory Boards" (CABs).
2. In 2000, OAPP began implementing the "Service Provider Network" (SPN) mechanism—a vehicle through which planning, evaluation and coordination of services can be performed at the SPA level.
3. In 2001, the Commission adopted a continuum of care and plan which relies on more localized planning based at the SPA level.
4. In 2002, the Commission launched a public awareness campaign to educate the community about the role of the Commission, to promote the availability of services, and to recruit consumers and community members alike to become involved. Although the campaign was temporarily suspended, the Commission fully expects to re-initiate it in the near future.
5. In 2002, the Commission met HRSA's requirements of nonaligned consumer membership on the planning council.
6. Consumer projects have been identified as part of the phase of strategic planning process.

As the Commission is poised to implement its Comprehensive Care Plan in FYs 2002, 2003 and beyond, it is ready to take the next important steps to significantly expand consumer involvement in the EMA's planning and service arenas. In FY 2003, the Commission will launch a major consumer involvement initiative establishing a structure and framework to permanently secure the role of consumers in local HIV/AIDS planning efforts.

In 2003, the Commission will require each of the eight providers coordinating SPNs to create CABs in each of the eight SPAs (some have already done so). The SPNs will rely on local provider CABs, local SPA consortiums, local Coordinated Provider Networks (CPNs) and other SPA-based coordinating councils to recruit and recommend consumer members to the SPN CABs. The SPNs will also be expected to recruit consumers to their respective CABs who are not necessarily affiliated with any of the other SPA- and/or provider-based groups. The SPNs will be expected to design a role for their CABs in their planning processes. The Commission—through its Priorities and Planning (P&P) and Recruitment, Diversity and Bylaws (RD&B) Committees—will provide technical assistance and guidance to the SPNs in these efforts.

In 2004, the Commission will establish a Los Angeles County HIV/AIDS Consumer Council as an advisory body to the Commission. The Consumer Council will rely on the SPNs to recruit

and select representatives to the Council from each of their respective CABs. The Commission's P&P and RD&B Committees will spend FY 2003 developing the specifics of the Consumer Council structure, such as composition, goals and responsibilities. During this time, the RD&B Committee will also begin planning the extension of the Commission's comprehensive training program to the Consumer Council and the CABs at the SPA and provider levels.

The Commission expects to supply the Consumer Council and the SPN CABs with definable roles and duties and to invest them with real authority. In other EMAs where this structure has been effective, the Consumer Councils are responsible for, for example, needs assessments, priority-setting, allocations and/or a host of other outcome related responsibilities mandated by HRSA. The key to this initiative's success, cited by most other EMAs, is that involved consumers feel accountable and take ownership of the planning process and recommendations.

The benefits of this initiative are enormous:

1. a more empowered and engaged consumer populace with a voice in EMA planning efforts;
2. a service delivery system more responsive to localized needs and interests;
3. a planning council recruitment and leadership development mechanism for consumers; and
4. a better educated and self-reliant consumer clientele.